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LONG-TERM CARE INSURANCE

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

SECOND SESSION

AUGUST 2, 4; AND SEPTEMBER 26, 1988

Serial 100-80

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LONG-TERM CARE INSURANCE

TUESDAY, AUGUST 2, 1988

House of Representatives,
Committee on Ways and Means,
Subcommittee on Health,
Washington, DC.

The subcommittee met, pursuant to call, at 2 p.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
TUESDAY, JULY 26, 1988

PRESS RELEASE #23
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE FORTNEY PETE STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES TWO HEARINGS ON LONG-TERM CARE TO BE HELD ON TUESDAY, AUGUST 2, AND THURSDAY, AUGUST 4, 1988

The Honorable Fortney Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold two hearings on long-term care for our nation's elderly and disabled.

The first hearing will be to receive testimony on long-term care legislation from Members of Congress only.

The hearing will be held on Tuesday, August 2, 1988, beginning at 2:00 p.m., in room 1100 Longworth House Office Building.

The second hearing will focus on the general topic of the need for long-term care insurance. This hearing will be held on Thursday, August 4, 1988, beginning at 10:00 a.m., in room 1100 Longworth House Office Building.

The second hearing will include testimony from Joshua M. Wiener, Ph.D., Senior Fellow, The Brookings Institution, as well as representatives from the American Association of Retired Persons, the National Council of Senior Citizens, the Health Insurance Association of America, Consumers Union, the American Council of Life Insurance, the National Association of Home Care, the American Healthcare Association and the American Association of Homes for the Aging.

In announcing the hearings, Chairman Stark said, "The Congress must respond to the growing need of senior citizens for long-term care protection. Medicare should be expanded to provide coverage for long-term care costs. There is also a need for Federal standards to regulate private long-term care insurance to protect older Americans from worthless policies and fly-by-night insurance companies."

Chairman Stark has introduced H.R. 5085, the Long-Term Care Insurance Standards Act of 1988, which would regulate private long-term care insurance policies along the lines now used to regulate Medigap policies.

At these hearings, oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for inclusion in the printed record of the hearing.

BACKGROUND

Currently in the United States, there are not adequate private or public mechanisms for assisting people to pay for long-term care. The long-range demographics of the nation will increasingly strain this imperfect system. In the next

(MORE)

thirty years, the elderly population will more than double, while the group aged 85 and over, who are most likely to need long-term care, will almost triple. Although the income of the elderly is rising, the income of the age-85-and-over population will not keep pace with the cost of care.

Some 2.3 million of the nation's elderly are living in nursing homes and this number is expected to increase 100 percent in thirty years. Equal numbers of the elderly will also require long-term home and community based care. Nursing home care now costs an average $22,000 a year. By the year 2018, it will cost about $55,000 if inflation stays at recent rates.

Medicare pays only two percent of nursing home expenditures. Medicaid currently pays almost half of the $38 billion cost for nursing home care. The other half of the $38 billion is paid by nursing home residents or their children.

Both public and private initiatives are needed to finance long-term care. The issue is how to strike the appropriate balance between public and private financing.

MEMBERS OF CONGRESS REQUESTS TO BE HEARD:

Members of Congress interested in testifying should have their staffs contact Michele Heigle or Debra Greathouse of the Subcommittee staff (telephone 225-7785) by the close of business Friday, July 29, 1988, or the request may be made by formal written request addressed to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, room 1102 Longworth House Office Building. Any questions regarding a scheduled appearance should be directed to the Subcommittee staff.

Members testifying before the Subcommittee are requested to submit 150 copies of their prepared statements to the Subcommittee on Health office, room 1114 Longworth House Office Building, by noon, August 1, 1988. (See formatting requirements below.)

WRITTEN STATEMENT IN LIEU OF PERSONAL APPEARANCE

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Friday, July 29, 1988, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and pubic if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

FOR IMMEDIATE RELEASE
MONDAY, SEPTEMBER 12, 1988

PRESS RELEASE #25
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE FORTNEY PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A HEARING ON
LONG-TERM CARE
TO BE HELD ON MONDAY, SEPTEMBER 26, 1988

The Honorable Fortney Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee on Health will hold a hearing on long-term care for Medicare elderly and disabled beneficiaries.

The hearing will be held on Monday, September 26, 1988, beginning at 2:00 p.m., in room 1100 Longworth House Office Building.

The hearing will include testimony from: T. Franklin Williams, M.D., Director, National Institute on Aging; Robert Kane, M.D., Dean of the School of Public Health, University of Minnesota; Stanley J. Brody, J.D., Director, Research and Training Center for Rehabilitation of Elderly Disabled Individuals, University of Pennsylvania Medical Center; Mark Meiners, Ph.D., Director, Robert Wood Johnson Foundation Program to Promote Long Term Care Insurance for the Elderly; and Kevin J. Mahoney, Ph.D., Principal Investigator for Connecticut's Long Term Care/Medicaid Program.

In announcing the hearing, Chairman Stark said, "The Congress must better address the long-term care needs of our Nation's elderly and disabled. Other countries do provide long-term care for their disabled citizens without requiring them to bankrupt themselves while preserving their dignity. We can do the same for our chronically disabled."

At this hearing, oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for inclusion in the printed record of the hearing.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Friday, October 21, 1988, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

SEE FORMATTING REQUIREMENTS BELOW:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

Chairman **Stark**. The Subcommittee on Health of the Committee on Ways and Means will commence its hearing and we are going to begin a series of witnesses dealing with the issue of long-term care.

This is a universal problem and sooner or later every family has to deal with it. For all but the very rich in this country, paying for this care can quickly bankrupt an individual or their relatives.

Although there is no consensus on what role the Federal Government should play, there is a growing consensus that the problem makes reform essential, and needs addressing by the Congress to define what the Federal role should be.

Members in both Houses and on both sides of the aisle have introduced legislation. In particular, Senator Pepper has introduced H.R. 3436, the Medicare Long-Term Home Care Catastrophic Act, and Senator Mitchell has sponsored S. 2305, the Long-Term Care Assistance Act.

The problem of ensuring that our Nation's chronically disabled elderly live in dignity must be addressed. The number of Members requesting to testify at today's hearing strongly indicates that the subcommittee must begin the process of developing legislation to aid those requiring long-term care.

In an effort to give all the Members—I think over 17 have asked to testify today—an adequate opportunity, before we go about our business this evening, I am going to ask unanimous consent of the members of the committee that we limit the witnesses appearing to 5 minutes to summarize their testimony with the exception of Senator Pepper and Senator Mitchell, both of whom have comprehensive bills, and I would request that they be extended 15 minutes in which to summarize or explain their positions.

Without objection, that will be the rule.

I would like to welcome our colleagues who have taken time from their busy schedules to prepare their testimony and to be with us today.

I am honored to welcome our first witness, a gentleman who has accommodated this gentleman, the Chair of this committee, and who has also accommodated the Chair of the full committee, its ranking member, and its majority members through these past 2 years as we have attempted to expand Medicare benefits.

I hope this is the first step in repaying the gentleman from Florida's graciousness, his cooperativeness, and his unyielding assistance in seeing that we improve the stature of seniors in this country.

Before I recognize the distinguished gentleman from Florida, I would like to yield to Mr. Gradison, our ranking member.

Mr. **Gradison**. Mr. Chairman, I thank you for making this time available.

I concur completely in your opening statement.

This is the beginning of what I am sure is going to be a very lengthy process, and properly so, because whatever decisions we make in this field are going to be important to our country for decades to come, and we want to make sure we do it the right way.

I am particularly pleased to see the first of the hearings we will be holding this year get started because this is very complex legislation, the proposal introduced, and there continue to be major new proposals introduced frequently in both the House and the Senate that suggest there are important policy issues to be faced with regard to benefit structure as well as financing.

I am glad we are taking those first, but essential first steps.

Thank you, Mr. Chairman.

Chairman STARK. Mr. Pickle.

Mr. PICKLE. I want to welcome Senator Pepper here.

When we voted a couple of months ago to postpone long-term care, it was not a reflection on the Congress that we were not willing to consider this measure, but rather it was a request for more time.

The Congress must come face to face with this long-term care issue, and while I don't know exactly what form the legislation will take, I have said to the House and I say again that it will become known as the Pepper bill because of this gentleman's long-term commitment to long-term care.

He is a very caring, thoughtful, almost unbelievable man of our times.

I salute you and call you the greatest Roman of them all, and we are glad to have you here today.

Mr. PEPPER. Thank you.

Chairman STARK. Mr. Anthony.

Mr. ANTHONY. Mr. Chairman, thank you.

I would like to also welcome Senator Pepper and pledge to not only you, Senator, my personal effort and support as a member of the Subcommittee on Health that we will travel this road together. I don't think there is any question that when the legislation is passed, I think all the people who will be affected by it in a beneficial way will know it is your efforts over a long period of time that brought the consciousness to the Congress and to the public to achieve it.

I look forward to working with you.

Chairman STARK. Welcome, Senator.

Without objection, any prepared material that you have will be made a part of the record in its entirety.

STATEMENT OF HON. CLAUDE PEPPER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA, AND CHAIRMAN, SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE, SELECT COMMITTEE ON AGING

Mr. PEPPER. Thank you very much, Mr. Chairman and members of the committee.

I want to commend you and your committee for holding this hearing and for the initiative you are taking to see to it that improved health care is made available to the people of our country.

I appreciate very much the privilege of being with you here today.

I agree, Mr. Chairman, and I think most of us do with what President Kennedy said in 1962. He said I consider that availability of adequate health care is a prerequisite to the enjoyment of the constitutional guarantees of the pursuit of happiness and he said if our medical system does not afford that opportunity, it is our duty to change it, for, he said, a society is judged by the degree to which it fulfills the promise of a longer and better and happier life for its people.

I think we agree to those principles.

When you look at the scope of the medical care available to the people of the country today, Mr. Chairman and members of the committee, you observe that with respect to hospitalization, the elderly are now well taken care of, thanks to our valuable contribution and passage of the catastrophic bill a little while ago. And in certain other areas also, that bill made considerable progress.

But do you realize that below 65 years of age down to the people who are the beneficiaries of the Medicaid program, except for the coverage provided generally by employers for their employees, do you realize that most of the American people do not have any Federal protection assuring them any adequate hospital care?

But in the field of long-term care, I think the need is even more critical and the demand more severe.

Only yesterday, one of our colleagues, Mr. Joe Kennedy and I held a hearing in Boston. The following statements are from two witnesses at that hearing. First, we heard from:

Mrs. Cheryl Sanborn, who spent all her savings and will soon have to sell her possessions to pay for the care of her 4-year-old son Gregory who is partially paralyzed and requires round-the-clock care. In addition, her grandmother suffered a stroke and needs home care and she has a 9-year-old daughter who suffers from leukemia. We were told that on September 6, her insurance will run out, depriving her even of that small financial support.

One other witness, Timothy Confrey, testified about how he spent his last 3 years caring for his mother who has Alzheimer's disease. As her condition deteriorated, Mr. Confrey gave up his job and moved in with his mother to attend to her needs. For the past 3 years, he has provided the bulk of his mother's care, often staying up days at a time.

Despite these efforts, they exhausted her life-time savings of over $25,000 and his of $10,000. Sadly, last year he was forced to put his mother on Medicaid which, in turn, put her in a nursing home for care, a place she told her son she never wanted to go.

In the August 8 issue of U.S. News & World Report, one of the lead articles is "The Next Big Ticket, Long-term Health Care." There are about two pages here of consideration of that subject.

When you think of it in perspective for the American people beginning with the oldest American down to the people who are covered by Medicaid, do you realize there is no long-term home care or nursing home care available to the people except those that are protected by contract through their employers? Forty million Americans don't have any insurance at all, and 10 million of those are children who are liable to have long-term care needs.

So my position is, Mr. Chairman, and I hope it will be the position of your distinguished committee that the first thing we should do is pass a long-term care bill for the chronically ill men, women and children, and I insist, Mr. Chairman, that we include children on that list.

There are some people already beginning to say—I don't believe with much justification—that it is becoming more or less a common criticism that we are already giving a little too much to the elderly.

We are not giving them too much and they need even more than they are getting.

They don't, for example, have long-term care, but they are no different in that respect than the rest of the population including the children of the country who are chronically ill.

I would like us to start with H.R. 3436 as a basic bill to provide long-term home care for every chronically ill man, woman and child in America and that we use the financing system that we propose in our bill H.R. 3436 extending the 1.45 percent Medicare tax to income over $45,000. Because as Lou Harris testified before my subcommittee, the poll that he conducted and we put into the record, showed that 83 percent of the people of this country favor that principle, that bill, and 73 percent of the people who pay the tax indicated they favored that method of financing.

The distinguished chairman of the Ways and Means Committee has assured me—I have informed members of the committee and Members of the Congress, that he would hold available that money for the use of this committee as you fashion legislation of that character in this or the coming year.

I don't know of any simpler, fairer, and more effective method of financing.

That tax will yield, according to the second and very conservative estimate of the Congressional Budget Office, $34 billion in the next 5 years, and our bill would cost about $27 billion.

There would be a surplus there of a few billion dollars. That could be used to augment the benefits, take care of any need that might appear or some other benefits which might be added on.

My suggestion is this: We start with H.R. 3436 as a basic bill, look at it carefully with scrutiny, can it be improved? If it can, let's improve it.

We want to make it the most effective bill we can. We all want to work together to accomplish that good.

We think we have structured the bill on a sound basis. We in that bill would not allow anybody to get the benefit of the bill unless a local group in the county where the aid was given recommended that that family be made a beneficiary. Then if they were made a beneficiary, a doctor, a nurse and an organizational person would have to determine what kind of care that family needed and only then would it be provided.

There are many other safeguards that are in the bill, but if you can improve it, by all means do it.

So let's start with H.R. 3436 and the method of financing that it provides, improving it in administrative quality and excellence in any way you can or in any other way, but start with that basic concept.

We are going to provide the most needed care the American people require today, long-term home health care for the chronically ill men, women and children.

Some Members have failed to include children in the legislation they have proposed.

I strongly disagree with that.

One hundred forty organizations working in great harmony and accord supported our bill. They strongly support, as does George Miller, the Chairman of the Select Committee on Children of the House, our bill to include the children.

Let's not let anybody talk us out of including men, women and children who are critically and chronically ill.

So starting with that concept and improving this bill as much as you can—from there on it is up to the committee to determine how much more you think you should spend.

In fashioning H.R. 3436, we didn't think that we should ask the Congress to appropriate more than about $34 billion in the next 5 years all together.

If you want to add on some home care, I would like very much to see it.

You will have to take the responsibility for increasing the amount of revenue that we will have to derive, unless you limit the amount of additional home care to the benefits to the difference between $27 billion expected cost and $34 billion anticipated revenue from the tax that we impose.

But beyond our bill which I think should be considered the basic bill improved as you can improve it, let that go ahead as our basic foundation for the President.

Remember, Mr. Chairman, in the catastrophic bill, we included the Pepper amendment which provides for a bipartisan commission to make a study during the period of a year of the health needs of our country.

In the first 6 months, the duty of that bipartisan commission would be to determine how much it would cost and where the money should come from to provide all needed home care and long-term care, nursing home and home. We only provide for home in our bill.

But the first 6 months of the duty of that commission would be to determine those facts and we will have it before us within 6 or 8 months.

I just spoke to the chairman of the Subcommittee on Appropriations a few minutes ago on the floor, and they are going to put in $1,200,000 to finance that bipartisan commission, and the Senate has already put it in.

The commission will be named and we will go into operation very shortly.

The next 6 months of the life of the commission would be to determine how much it would cost and where the money should come from to provide comprehensive care, medical care for every man, woman and child in America.

That is a long way from where we have been and it is a considerable distance from where we are.

This article here indicates one of the main issues in this coming election is long-term care and our democratic nominee, Governor Dukakis, has come out squarely and forcefully for our bill and for that principle.

So if we start with that base and enact H.R. 3436 amended as you think it should be amended and with whatever addition you want to add, we will make a good, solid, sound beginning on meeting the principal need of the American people in the immediate future.

Then we can wait if we need to for the report of the bipartisan commission which will give Congress the best information, the best data that we have ever had before this legislating upon these other critical subjects.

If I may, I will ask that this article in U.S. News & World Report be included.

Chairman STARK. Without objection, Senator, we will include that article, your typed statement, and your supplemental views as part of the record. I appreciate very much your laying down the gauntlet for us and describing for us the task that we have ahead of us for the remainder of this year and certainly early in 1989.

[The prepared statement and article follow:]

NEWS

CLAUDE PEPPER, Chairman
Subcommittee on Health and Long-Term Care
House Annex 2, Room 377
Washington, D.C. 20515
202/226-3381

Select Committee on Aging

U.S. House of Representatives

FOR IMMEDIATE RELEASE
TUESDAY, AUGUST 2, 1988
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STATEMENT OF THE HONORABLE CLAUDE PEPPER, CHAIRMAN, HOUSE SELECT COMMITTEE ON AGING'S SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE BEFORE THE WAYS AND MEANS SUBCOMMITTEE ON HEALTH ON

"LONG-TERM HEALTH CARE"

MR. CHAIRMAN. MEMBERS OF THE SUBCOMMITTEE. DISTINGUISHED GUESTS. IT IS A PLEASURE TO BE HERE AND DISCUSS WITH YOU MY VIEWS ON LONG-TERM CARE. AS YOU KNOW, THIS ISSUE IS OF IMMENSE IMPORTANCE TO ME AND TO MILLIONS OF AMERICANS. I WANT TO COMMEND YOU FOR TURNING YOUR ATTENTION TO THIS MATTER AND BEGINNING THE TASK OF DEVELOPING A LONG-TERM HEALTH CARE PROPOSAL FOR THE CHRONICALLY ILL OF OUR COUNTRY.

ONE MILLION AMERICANS OF ALL AGES ARE FORCED INTO POVERTY EACH YEAR TRYING TO PAY THE COSTS OF LONG-TERM ILLNESSES. WHY DOES THIS HAPPEN? THE FACTS SPELL IT OUT CLEARLY. MILLIONS OF AMERICANS ARE VICTIMS OF ILLNESSES OF LONG DURATION:

3 MILLION AMERICANS HAVE ALZHEIMER'S DISEASE;

5 MILLION AMERICANS HAVE CANCER;

10 MILLION CHILDREN HAVE CHRONIC HEALTH PROBLEMS;

1.5 MILLION AMERICANS SUFFER HEART ATTACKS EACH YEAR;

500,000 AMERICANS HAVE PARKINSON'S DISEASE;

4 MILLION AMERICANS ARE ACCIDENT VICTIMS EACH YEAR; AND

500,000 AMERICANS SUFFER STROKES EACH YEAR.

THE BULK OF THE CARE NEEDED BY THESE PEOPLE IS CUSTODIAL -- THAT IS, ROUTINE, DAY-DAY ASSISTANCE WITH SUCH ACTIVITIES AS BATHING, DRESSING, TOILETING AND THE LIKE. AND THE COSTS OF SUCH ARE ARE STAGGERING:

NURSING HOME CARE CAN COST AS MUCH AS $60,000 A YEAR. tHE AVERAGE COST NATIONALLY IS NOW OVER $24,000 A YEAR; AND

DAILY HOME HEALTH CARE COSTS AN AVERAGE OF $15,000 A YEAR.

AS YOU WOULD EXPECT, THE AVERAGE AMERICAN FAMILY DOES NOT HAVE THE RESOURCES TO PAY FOR LONG-TERM CARE:

THE AVERAGE AMERICAN FAMILY HAS 3.2 PERSONS;

THEIR MEDIAN INCOME IS $27,3000;

BOTH HUSBAND AND WIFE WORK; AND

THEY HAVE LESS THAN $10,000 IN LIQUID ASSETS.

AT PRESENT, NEITHER PUBLIC NOR PRIVATE INSURANCE PROVIDES PROTECTION AGAINST THE COSTS OF LONG-TERM CARE:

MEDICARE PAYS ONLY FOR LIMITED AMOUNTS OF SKILLED NURSING HOME AND HOME HEALTH CARE. MEDICARE PAYS FOR LESS THAN 2 PERCENT OF NURSING HOME COSTS;

MEDICAID GENERALLY PAYS ONLY FOR NURSING HOME CARE AND REQUIRES PAUPERIZATION BEFORE ELIGIBILITY CAN BE GRANTED. TYPICALLY, ONE HAS TO SPEND DOWN TO $1,500 IN INCOME AND $2,500 IN ASSETS TO QUALIFY FOR MEDICAID; AND

MOST PRIVATE HEALTH INSURANCE PROVIDES LIMITED, IF ANY, OCVERAGE FOR LONG-TERM CARE IN THE HOME OR IN A NURSING HOME. NEW SPECIALIZED LONG-TERM CARE POLICIES ARE EXPENSIVE, AND RIDDLED WITH LIMITATIONS AND EXCLUSIONS.

YESTERDAY, I JOINED MY COLLEAGUE JOE KENNEDY IN CONVENING A HEARING ON LONG-TERM HOME CARE IN SOMERVILLE, MASSACHUSETTS. EVEN IN THE STATE OF MASSACHUSETTS WHERE COMMENDABLE PROGRESS HAS BEEN MADE, LONG-TERM CARE REMAINS A LARGELY UNMET NEED AND A BANKRUPTING TRAGEDY. FOR EXAMPLE, WE HEARD FROM:

MRS. CHERYL SANBORN WHO SPENT ALL HER SAVINGS AND WILL SOON HAVE TO SELL HER POSSESSIONS TO PAY FOR THE CARE OF HER 4-YEAR-OLD SON, GREGORY, WHO IS PARTIALLY PARALYZED AND REQUIRES ROUND-THE-CLOCK CARE. IN ADDIITON, MRS. SANBORN'S GRANDMOTHER SUFFERED A STROKE AND NEEDS HOME CARE, AND SHE HAS A 9-YEAR-OLD DAUGHTER WHO SUFFERS FROM LEUKEMIA. WE WERE TOLD THAT ON SEPTEMBER 6 HER INSURANCE WOULD RUN OUT DEPRIVING THEM EVEN O THAT SMALL FINANCIAL SUPPORT.

MR. TIMOTHY CONFREY TESTIFIED ABOUT HOW HE SPENT THE LAST THREE YEARS CARING FOR HIS MOTHER WHO HAS ALZHEIMER'S DISEASE. AS HER CONDITION DETERIORATED, MR. CONFREY GAVE UP HIS JOB AND MOVED IN WITH HIS MOTHER TO ATTEND TO HER NEEDS. FOR THE PAST THREE YEARS, MR. CONGREY HAS PROVIDED THE BULK OF HIS MOTHER'S CARE HIMSELF, OFTEN STAYING UP DAYS AT A TIME. DESPITE THESE EFFORTS, THEY EXHAUSTED HER LIFETIME SAVINGS OF OVER $25,000 AND HIS OF $10,000. SADLY, LAST YEAR HE WAS FORCED TO PUT HIS MOTHER ON MEDICAID, WHICH IN TURN PUT HER IN A NURSING HOME FOR CARE -- A PLACE SHE TOLD HER SON SHE NEVER WANTED TO GO.

AS YOU GIVE CONSIDERATION TO THOSE ELEMENTS WHICH WOULD MAKE UP THE STRONGEST POSSIBLE LONG-TERM HOME CARE BILL, I WOULD SUGGEST THAT YOU WOULD KEEP IN MIND THE STORIES OF MRS. SANBORN AND TIMOTHY CONFREY. THE LONG-TERM CARE BILL DEVELOPED BY THIS SUBCOMMITTEE SHOULD USE THE PEPPER-ROYBAL LONG-TERM HOME CARE BILL AS ITS FOUNDATION. IT SHOULD COVER ALL CHRONICALLY ILL AMERICANS, THE YOUNG, THE OLD, THE DISABLED. IT WOULD BE A SERIOUS MISTAKE TO DO OTHERWISE. ELIGIBILITY FOR LONG-TERM CARE SHOULD NOT BE BASED ON AN INDIVIDUAL'S OR THEIR FAMILY'S INCOME. IT SHOULD BE KEYED TO THE INDIVIDUAL'S FUNCTIONAL LIMITATIONS SUCH AS PROPOSED IN THE PEPPER-ROYBAL BILL.

THE FINANCING OF A LONG-TERM CARE PROPOSAL SHOULD BE SIMPLE, UNDERSTANDABLE, AND BASED ON SOCIAL INSURANCE PRINCIPLES. THE PEPPER BILL IDENTIFIED THE SOURCE OF FINANCING FOR THE LONG-TERM HOME CARE BENEFIT AND THIS FINANCING MECHANISM IS WIDELY SUPPORTED BY THE AMERICAN PUBLIC. I AM PLEASED TO NOTE THAT THE CHAIRMAN OF THIS COMMITTEE HAS AGREED TO RESERVE THESE MONIES FOR LONG-TERM HOME CARE.

I WOULD HOPE YOU WOULD REPORT THE PEPPER BILL WITH ANY TECHNICAL AMENDMENTS YOU OR OTHERS WOULD SEE FIT. BEYOND MY BILL, I WOULD ENCOURAGE YOU TO PROVIDE FOR CUSTODIAL NURSING HOME WHEN SUCH CARE BECOMES UNAVOIDABLE. I STILL BELIEVE, AND MY VIEW IS SHARED BY THE MAJORITY OF AMERICANS, THAT HOME CARE IS THE PERFERRABLE SITE FOR RECEIPT OF LONG-TERM CARE SERVICES.

IN CONCLUDING, I FEEL STRONGLY THAT IT WOULD BE UNWISE TO FURTHER BURDEN THE ELDERLY AND DISABLED WITH ADDITIONAL PREMIUMS OR TAXES TO PAY FOR THIS NEW LONG-TERM CARE BENEFIT.

I LOOK FORWARD TO WORKING WITH YOU IN COMING MONTHS TO SEE THE ENACTMENT OF LEGISLATION IN THIS IMPORTANT AREA.

The next big ticket: Long-term health care

The elections will help to decide who pays–and how much

"He has a mother who is very much of a senior citizen."
—Euterpe Dukakis, age 84, at last month's Democratic convention

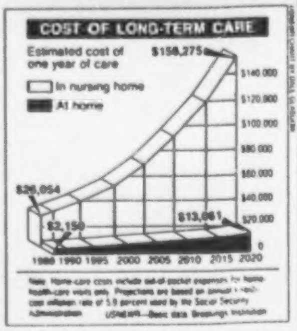
"If we have any problems with your son, we'll come to you."
—Representative Claude Pepper (D-Fla.), age 87

It may be the social contract behind the 1988 election. Nearly 30 million elderly voters will help select the next President—and whether he's the son of Euterpe Dukakis or 87-year-old Dorothy Bush, he'll no doubt respond with a program for long-term care. Providing and paying for treatment of the chronically ill or disabled has become a paramount issue in the presidential race and some House and Senate contests as well. More than 100 long-term-care bills have been dropped in the hopper in Congress, while a slew of additional proposals are on the way. The elections will help to decide which version prevails—but passage of long-term-care legislation "is as inevitable as the setting of the sun," Senator George Mitchell (D-Me.) predicts.

A family affair. The issue is one of the most pressing problems the nation faces. America's growing and aging population is requiring more nursing-home stays, home health-care services and a range of other support activities to allow the sick or disabled to live outside institutions. But the U.S. currently has no comprehensive program for providing long-term care or for paying the exorbitant cost. A year in a nursing home runs an average of $26,000 (see chart), while medicare and medicaid pay only a fraction of the tab. In fact, the bulk of long-term care is paid for by individuals or performed by friends or relatives, most of whom are women. That's one reason why long-term-care legislation has become a family issue—and why polls show the majority of voters would support it, even if it meant higher taxes.

Congress began to grapple with long-term care last spring, when the House considered a costly and controversial home-care bill backed by Dukakis and seniors' champion Pepper (and opposed by Bush and the Reagan administration). The victim of a congressional turf battle, the measure was voted down in June—but its defeat helped to focus a broad debate over long-term-care issues. The discussion is in part ideological, exposing deep differences between many Democrats and Republicans. Yet it's also a highly technical deliberation over how to meet many different needs—while somehow controlling the cost of care that could run $20 billion to $60 billion a year.

Should the elderly or everyone get care?



Note: Home-care costs include out-of-pocket expenses for home health-care visits only. Projections are based on annual [illegible] cost inflation rate of 5.9 percent used by the Social Security Administration. USN&WR—Basic data: Brookings Institution

Spending into poverty. Most policymakers share at least one concern: The desire to shore up the fragmented long-term-care payment system and modify the role of medicaid. The joint federal, state and local program was primarily designed to pay for health care for the poor—but since it also covers nursing-home costs, it now pays 42 percent of the $40 billion annual tab for such care. Yet the extent of medicaid coverage varies greatly from state to state—and the program's notorious "spend down" provisions require senior citizens to deplete much of their income and assets (excluding their homes or personal effects) before it will pay for their nursing-home stays. Although the catastrophic-health-costs law passed recently eased those requirements somewhat, the problem is still viewed as an inhumane aspect of the system. By contrast, "we'd never tell people they had to spend down their assets or impoverish their spouse before we'd let them in the hospital," says Jack Meyer, a Washington health economist.

Social insurance or private market? Legislators and policymakers differ over how to make things better. The crux of the debate is whether to replace the system with a new public "social insurance" program, like Social Security or medicare—or to encourage the private market to absorb more of the cost of long-term care. In general, many Democrats lean toward the former: This week, Massachusetts Senator Edward Kennedy will introduce a bill that would create a new "lifecare" program to pay the lion's share of nursing-home and home-care expenses for the elderly. At a net cost of at least $19 billion a year, the program would be funded by premiums paid by the elderly and hikes in payroll taxes on the upper middle class. Kennedy argues that only such social insurance would "provide the protection that people need and deserve"—while sparing them the hefty administrative and

AFFORDABLE HEALTH CARE
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POWER

Like many other Democrats, Pepper calls for a public program—while most Republicans prefer a private-sector approach

marketing expenses built into the cost of private insurance.

Many Republicans see more promise and less cost in tapping the private sector. The market for private long-term-care insurance policies is growing, but it's still small; insurers, leery of future costs, have been slow to offer the policies, which until lately have provided limited coverage or have been extremely expensive. But Bush, along with other Republicans like Senator David Durenberger (R-Minn.), is pushing tax-law changes and other measures to broaden private insurance coverage. One approach: Clarify the tax code to encourage employers to take deductions and offer long-term-care insurance as a benefit for employes and their parents. If companies and workers bought the idea—an uncertain prospect—such coverage could eventually help protect about one third of the elderly, at the cost of forgone tax revenue.

A grand compromise. Some policymakers are pushing plans that they say would provide the best of both worlds—marrying private insurance coverage with public programs. (Despite Dukakis's embrace of the Pepper bill, advisers say he's worried about long-term-care costs and may actually be more inclined toward this solution.) A bill proposed by Senator Mitchell would expand medicare to pay for home care—but as a cost-saving measure, it would require individuals to purchase private insurance to pay for their first two years in a nursing home. And with the help of $3 million in grants from the Robert Wood Johnson Foundation, a handful of states are exploring ways to use private insurance to attack the spend-down problem. In a plan known as the Connecticut Partnership for Long-Term Care, a public-private group in that state proposes that the elderly could buy some private insurance—say, a one-year, $25,000 policy for a $400 annual premium. When that coverage was used up, these individuals could go on medicaid, but they'd be able to keep a protected level (in this case, $25,000) of assets.

Who and what gets covered? The vast majority of those who need long-term care are elderly. But by the year 2000, an estimated 40 percent are expected to be disabled children and younger adults (in part because medical advances will keep more sick people alive). With the exception of Pepper's bill, most long-term-care plans wouldn't cover them, since that could cost $5 billion or more a year.

An even larger issue is precisely what services should be provided or paid for. Many long-term plans propose to cover only health-care services—but experience shows that even paying for such services as mowing the lawn is sometimes enough to keep a senior citizen out of a nursing home. Still, these services would have to be organized and offered in communities—and to forestall a massive public giveaway, thousands of paid case managers would have to carefully assess elder citizens' needs. Creating such a complex but cost-effective system would require "a lot more flexibility than we're used to building into [public programs]," observes Mark Schlesinger, a health economist at Harvard.

Sorting through these and other complexities won't be easy. A bipartisan congressional commission created by the catastrophic-care law is supposed to make its recommendations next January. But given the broad spectrum of opinion over long-term care, it's unlikely the panel will reach a consensus. Pepper, however, is optimistic. "I feel confident that, within a year from now, we'll have long-term-care [legislation]," Pepper says. The next President will have a big hand in deciding what that law looks like—with a little help from his elders. ■

by Susan Dentzer

Chairman STARK. Mr. Gradison.

Mr. GRADISON. No questions.

Thank you, Mr. Chairman.

Chairman STARK. Mr. Donnelly.

Mr. DONNELLY. I have no questions, Mr. Chairman.

Chairman STARK. Thank you, Senator, very much.

Mr. PEPPER. Thank you very much, Mr. Chairman.

Chairman STARK. I am happy to call to the witness stand the Honorable Ben Gilman, the gentleman from New York.

I am afraid you weren't here, Ben, when we suggested that we were going to run the time clock on Members and ask them to summarize or expand on their prepared statements in 5 minutes. Because of the schedule for many of those testifying and the schedule of votes on the House floor today, we may have a disruptive schedule.

I am happy to see you before the committee. I know this is an issue with which you have long been involved and concerned.

Without objection, your statement will be inserted in the record in its entirety, so why don't you go ahead and enlighten us or expand on your testimony in any manner you are comfortable with.

STATEMENT OF HON. BENJAMIN A. GILMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. GILMAN. Thank you, Mr. Chairman.

I have submitted the full statement for the record and I will try to summarize my position.

Members of the committee, I want to thank you for allowing us to provide our opinions today on the pressing topic of long-term health care. My colleagues are fully aware of the tremendous support throughout the Nation for expanded Federal programs to protect against the devastating effects of long-term illness. As a leading Republican advocate and cosponsor of the legislation offered by our venerable chairman of the House Rules Committee, the distinguished gentleman from Florida, I appreciate the committee's willingness to consider this matter in a prompt and timely fashion before we complete our business for this session. While I voted to allow for full House consideration of the legislation along with some 169 of our colleagues, including 153 bipartisan cosponsors, I recognize that the Ways and means Committee is desirous of affording this problem the most thorough possible analysis, and we appreciate your attention to the issue.

Mr. Chairman and members of the committee, the Pepper bill framework for viewing the long-term care dilemma has many beneficial aspects. Perhaps most importantly, this proposal would have the desirable consequence of ensuring all Americans, young and old alike, against the high costs typically associated with catastrophic illness. In addition, the bill maintains a level of compassion commensurate with the degree of suffering experienced by the victims of long-term illness.

Finally, I recommend that the committee retain the financing mechanism in the original Pepper legislation which eliminates the cap on income subject to the Medicare payroll tax. While the change may impose a slight additional burden on those 5 percent of American workers who are affected, along with Senator Pepper, I feel that this change is necessary in order to protect the estimated 1 million or more Americans who are impoverished each year due to tragic long-term disabilities. I would venture to say that each of us have had this experience spelled out in a very dramatic manner in each of our districts.

I feel certain that the committee is aware of the resistance to this legislation based on the premise that expanded Medicare benefits will contribute to the burgeoning Federal budget deficit. Those arguments fly in the face of the Congressional Budget Office analysis of costs associated with this bill. This bill essentially pays for itself. Due to revenue collections which outpace benefit expenditures, the CBO indicated that enactment of the legislation would actually reduce the budget deficit by almost $2 billion in the first year and by roughly $6 billion over the first 5 years. For the mid-nineties and beyond, when the revenue picture might change, our proposal includes extensive safeguards to ensure that the bill remains self-financing.

It is too often ignored that Federal provision of long-term care insurance would achieve tremendous cost savings in other social programs which currently serve the victims of long-term illness, and I don't think that we can forget this aspect of the savings that would inure.

Mr. Chairman and members of the committee, I applaud your leadership and the efforts of the committee to expand coverage for long-term illness. At a minimum, however, I would urge the committee to retain the essential benefits of the original Pepper legislation. Should the committee see fit to provide further benefits such as coverage for nursing home costs, I would likely support such an effort. However, the final package should retain the Pepper bill emphasis on maintaining the quality of life, protecting all Americans, young and old, and paying for the benefits in a self-financing way which will avoid increasing the budget deficit.

I want to thank you for affording me the opportunity to testify in support of this important measure.

Chairman STARK. Ben, thank you.

[The statement of Mr. Gilman follows:]

STATEMENT OF REPRESENTATIVE BENJAMIN A. GILMAN, TWENTY-SECOND DISTRICT OF NEW YORK, BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON WAYS AND MEANS, REGARDING LONG-TERM HEALTH CARE.

August 2, 1988

Mr. Chairman, Members of the Committee, I would like to take this opportunity to commend you for holding today's hearings on the pressing topic of long-term health care. My colleagues are well aware of the tremendous support throughout the Nation for expanded Federal programs to protect against the devastating effects of long-term illness. As a leading Republican advocate and co-sponsor of the legislation offered by our venerable Chairman of the House Rules Committee, the distinguished Gentleman from Florida, [Mr. Pepper], I appreciate the Committee's willingness to consider this matter in a prompt and timely fashion. While I voted to allow for full House consideration of the legislation, along with 169 of my colleagues including the 153 bi-partisan co-sponsors, I recognize that the Ways and Means Committee is desirous of affording this problem with the most thorough possible analysis.

Nonetheless, I would commend to the Committee's attention the many merits of the original Pepper bill offered this summer. H.R. 3436 (formerly H.R. 2762) would establish five Activities of Daily Living (ADL's) comprising the minimum essential body functions necessary for the maintenance of quality of life. A disabled person's incapacity to perform any two of the five ADL's would be sufficient to qualify the individual for newly created home care benefits.

Mr. Chairman, this framework for viewing the long-term care dilemma has many beneficial aspects. Perhaps most importantly, our proposal would have the desirable consequence of insuring all Americans, young and old alike, against the high costs typically associated with catastrophic illness. In addition, our method would provide a concrete way for the state and local management agencies established in the legislation to determine eligibility for coverage. Finally, our bill maintains a level of compassion commensurate with the degree of suffering experienced by the victims of long-term illness.

Furthermore, I recommend that the Committee retain the financing mechanism in the original Pepper legislation. H.R. 3436 would have eliminated the cap on income subject to the 1.45 percent Medicare payroll tax. This is a progressive change in the tax law which would affect only those 5 percent of American workers who earn more than $45,000 a year in taxable income. While the change may impose a slight additional burden on those affected, along with Senator Pepper, I feel that this change is necessary in order to protect the estimated 1 million or more Americans impoverished each year due to tragic long-term disabilities. It appears that the American public concurs with our assessment. According to a nationwide survey conducted by Lou Harris & Associates, fully 7 out of 10 Americans would favor such a financing mechanism to provide long-term health care for all Americans.

Finally, Mr. Chairman, I feel certain that the Committee is aware of the resistance to this legislation based on the premise that expanded Medicare benefits will contribute to the burgeoning Federal budget deficit. These arguments fly in the face of the Congressional Budget Office (CBO) analysis of costs associated with H.R. 3436. Due to revenue collections which outpace benefit expenditures, CBO indicated that enactment of H.R. 3436 would actually reduce the budget deficit by almost $2 billion in the first year and by roughly $6 billion over the first five years. In addition, the Federal provision of long-term care insurance would achieve tremendous cost savings in other social programs which currently serve the victims of long-term illness. At the state and local level, H.R. 3436 would have resulted in savings of roughly $2.5 billion. This bill pays for itself. For the mid-1990's and beyond, when the revenue picture might change, our proposal includes extensive safeguards to ensure that H.R. 3436 remains self-financed.

Mr. Chairman, I applaud your leadership and the efforts of the Committee to expand coverage for long-term illness. At a minimum, however, I would urge the Committee to retain the essential benefits of the original Pepper legislation. Should the Committee see fit to provide further benefits, such as coverage for nursing home costs, I would likely support such an effort. However, the final package should retain the Pepper bill emphasis on maintaining the quality of life, protecting all Americans young and old, and paying for the benefits in a self-financing way which avoids increasing the budget deficit.

Thank you for affording me this opportunity to testify.

Chairman **Stark**. I just wondered—what do you think we ought to include in the way of additional benefits?

I think many people feel that just dealing with home health care is really going to solve a major part of the long-term care problems.

Do you have any kind of priorities on what you would like to see added as possible additional benefits?

Mr. **Gilman**. If we could get into the nursing home care problems, I think it would be extremely helpful.

These costs are devastating to the average family. They can wipe out a family's income after just a short period of time trying to take care of some of the elder members of family, and it is becoming an increasingly burdensome problem for the average family across the Nation.

Whatever we can do to help ease that burden, I think, would be beneficial.

Chairman **Stark**. Let me do some back-of-the-envelope math with you.

It is my understanding that there are about 15 million, or half the seniors on Social Security that have incomes of less than $12,000 a year, and I think Senator Pepper testified that the average cost in this country for a nursing home is $24,000 a year, and it can run as high as $60,000.

Let's assume for a minute that we were going to provide that minimum standard of living, that extra $10,000, $12,000 a year to 15 million people.

We are talking $15 billion for openers. Now, that is if all these people applied.

One would presume that if you try to live on $12,000 and suddenly someone gives you the opportunity to have three square meals a day and clean sheets and a color television in the club room, you might opt very quickly for that higher living standard.

But maybe only a third of those would take it; even so, that is still $5 billion a year.

My question is, How do we consider financing it? This is over and above what we would have to use in Senator Pepper's bill.

We have heard that we should just do it, for instance, from State gift taxes, possibly increasing payroll taxes further or as we did in catastrophic, charging the more well-to-do elderly some higher premium.

Do you have a feeling if we are going to expand these benefits, which way we ought to head in paying for them?

Mr. **Gilman**. A poll shows by a 5 to 2 margin respondents expressed a willingness to pay the tax.

I think a more practical solution would be somewhat of a balance between public and private insurance and have both the employer and the employee make contributions. I believe that we could probably work out a satisfactory balance so that we can provide the kind of insurance that is needed to take care of these long-term needs that virtually every family is faced with at one time or another.

It has been suggested that the heaviest burden be placed on those above the $45,000 income threshold. That can be one of the considerations as we try to address the problem.

I think trying to maintain progressive funding as much as possible is another important consideration. I think certainly there are ways that we can help to make this self-financing and yet take care of a very important burden that is facing our Nation.

Chairman STARK. Thank you.

Mr. Gradison.

Mr. GRADISON. No questions.

Mr. GILMAN. Thank you, Mr. Chairman.

Chairman STARK. Thank you very much. I am happy to welcome our next witness, Hon. Mary Rose Oakar.

It is good to see this gentlewoman from Ohio. Right on time.

STATEMENT OF HON. MARY ROSE OAKAR, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Ms. OAKAR. Thank you, Mr. Chairman.

It is the first time I didn't have to wait, not for your committee, Mr. Chairman, but for my own committee.

Chairman STARK. Thank you for joining us.

Your prepared testimony will appear in the record in its entirety.

We have been attempting to limit Members to 5 minutes to summarize or expand on their prepared testimony in any way that they are comfortable. This will allow us some time for questions and to accommodate all the Members who requested to testify.

So having said that, why don't you proceed in any manner that you are comfortable.

Ms. OAKAR. Thank you.

Mr. Chairman, let me thank you and the distinguished members of this committee, and I understand the Senate Members as well, for having this important hearing.

You have been a champion along with members of this committee of addressing the needs of older and disabled Americans, and I can tell you how I feel about the fine work that you have done in the past.

This is certainly a futuristic notion whose time has come.

I would like to ask unanimous consent to submit my entire testimony for the record and just speak extemporaneously.

Chairman STARK. Without objection.

Ms. OAKAR. Mr. Chairman and Members, I don't have to tell this committee that the fastest growing population in the country are people over 85. What we have today is a situation where you have 7-year-old kids taking care of 80-year-old grandparents and young people who are taking care of frail and elderly parents.

When you can't do it without the Federal services, sometimes it leads to problems like elderly abuse, so long-term care ought to be our goal. It ought to be comprehensive.

It is an issue that I and some of the distinguished members of the staff of this committee who used to be on my staff have worked on for a long time.

Basically, the way I feel about long-term care is we ought to get, No. 1, all the health providers together dealing with the situation.

There is a bias at times in terms of reimbursement toward nurses and dietitians and aides and services that people other than doctors and hospitals provide. And so we ought to look upon this concern as getting all the health providers that could deal with the elderly from the moment they enter into a medicare program to the end of their lives.

I think that is the only way to do it, and it would give them better care and also probably—in fact, I am sure—save a lot of money.

Second, we have some fine, outstanding pilot projects around the country that this committee is responsible for dealing with that ought to be part of an option. This is the spirit of the legislation that I have introduced over the last several years. There ought to be an option for people enrolled in the Medicare program, because it works and it is cheaper, and when you deal with people from this point of view of whatever their needs are, when you say to an older person, for example, "If you need ambulatory care, we will provide that care, if you need preventive care, we will give you that care.

"If you need nursing home care for an interim period, we will provide that kind of coverage in the long-term care philosophy."

When we do that, we know that is the way we don't unnecessarily house people in nursing homes, but by the same token, we deal with all their needs.

When you evaluate this over a period of time, you see that the bottom line is you save some money and you also deal with the person in a very human, dignified way.

So, Mr. Chairman and members, my legislation—which isn't the only answer, there are all kinds of wonderful options that have been introduced—is based on the 20 or more pilot projects that have worked.

We have one in my hometown of Cleveland. It is terrific. The people enrolled like it. They are satisfied. They get to choose the hospital or HMO. It is based on a team approach to comprehensive health care and as a result they are very, very happy.

So we know that over the last 4 to 6 years, we have had these pilot projects; that is what my bill is based upon and what it does is it calls for complete home help, homemaking services for those who can receive their need at home.

It has mental health services, adult day care services, supporting kinds of services.

It is hospital-based, but it also deals with the offer to the relatively frail of giving them nursing home care if they need that type of care as well.

I think if you give that kind of lifeline to the families in America, and to the elderly and disabled in particular, if you give them that option, which would have to be an option for them, I think you will not only make the older population a healthier population, but you will disarm the very negative aspects of American life for older people; namely, that when you become old, you are always in fear of losing everything you have ever had.

And, very simply put—the spirit of the legislation is a team approach. It offers a variety of health care needs, including nursing home care if a person needs that kind of care.

The nice thing about it, and you have some very well qualified staff who can verify this, is it doesn't cost anything more, it doesn't cost a nickel more.

So why don't we do that and treat people in a comprehensive fashion and still give them all their needs. So that is the spirit of what my whole attitude on this issue is.

I know that you had a difficult decision not long ago in terms of having to take a look at the Pepper bill.

Chairman **Stark**. Your demonstration project is financed by the Johnson Foundation. Is that the one that you were referring to?

Ms. **Oakar**. Yes, it was.

Chairman **Stark**. Do you have any figures? I am just not familiar with the cost side of that.

Ms. **Oakar**. We do.

Chairman **Stark**. As I have said, I know there are some social HMO experiments abroad in the land, but I have never had a chance, and I suppose I will as we continue these hearings, to get more details of what those costs are.

Ms. **Oakar**. We could do that, because what we found is that they are very predictive and they are in places all over the country.

We would be glad to supply that information.

[The information follows:]

Five-city Program Improves Health Care for the Underserved — at Reduced Cost

22 inner-city health centers provided expanded health services — especially for the poor, minorities, and children. Center patients had more doctor visits than other community residents, but dramatic reductions in hospital inpatient and outpatient use resulted in lower overall costs.

Summary and Findings

The Municipal Health Services Program (MHSP) was launched in June 1978 by The Robert Wood Johnson Foundation as a five-year effort to demonstrate whether large cities could develop coordinated systems of community-based medical and health services for the underserved. The program sought to substitute community-based health centers for hospital emergency and outpatient departments, which in many U.S. cities provided a substantial amount of primary care services for the poor, the elderly, and racial and ethnic minorities. The program also attempted to link these health centers with local public hospitals, to provide a continuum of outpatient and inpatient services.

Each of the five cities that participated in the program received a $3 million grant from the Foundation and had to meet stringent conditions related to patient utilization, provider productivity, and cost per patient visit.

The program was co-sponsored by the U.S. Conference of Mayors and the American Medical Association and received essential support from the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services. In its first venture with a private foundation, HCFA waived normal reimbursement rules for Medicare clients served in the program. The waivers permitted 100 percent reimbursement of reasonable costs for an expanded list of services. HCFA agreed to similar waivers for Medicaid clients, which also had to be supported by the states. In total, payments to MHSP health centers for services to Medicare and Medicaid clients exceeded $50 million.

Two independent evaluations of the program — one examining its implementation and the other its outcomes — were conducted by the Conservation of Human Resources of Columbia University and the Center for Health Administration Studies of the University of Chicago.

Among the program's most important results are the following:

- Eleven new community-based health centers were opened, and 11 preexisting centers were expanded. Three of the centers closed during the life of the program, but the 19 remaining are all open, and many are on an increasingly sound financial footing two years after most Foundation support ceased.
- Total visits grew from a baseline of about 101,000 per year in the preexisting centers to more than 451,000 at the program's conclusion; the number of visits per physician increased 49 percent.
- Center revenues more than doubled, and deficits as a percentage of expenses were trimmed by 50 percent, although a continuing subsidy is still required.
- MHSP expanded access to services for some groups it was intended to reach — especially the poor, children, and people who formerly relied on public hospitals, hospital outpatient departments, and emergency rooms for primary care.
- Contrary to expectations, the program did not attract a disproportionate share of elderly residents in most of the cities.
- Although Medicare clients who used MHSP centers received an expanded range of covered services, their Medicare costs were 42 percent lower

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This *Special Report* was based on the experience of the five cities in the Municipal Health Services Program, reports of its administrators and the researchers involved in its evaluation, field interviews with participants and other key individuals, and reports in the published literature care providers. These elderly individuals with chronic illnesses might have had well established ties to specific doctors or clinics. The projects may have been relatively ineffective in marketing to the elderly; or, the projects may have consciously decided *not* to market MHSP services aggressively and risk drawing fire from private physicians or other facilities.

According to HCFA, after 1982, marketing to the elderly was stepped up in some cities, and use of the program by Medicare clients increased significantly.

The majority of residents of the service areas around MHSP centers reported that their usual source of care was a private physician, in percentages ranging from 46 to 71 percent and averaging 62 percent. This finding, according to the Columbia research team, "substantially lessened the potential for shifting utilization from the public hospital to the neighborhood clinic."[7]

Nevertheless, the Chicago evaluation showed that by 1981-82, roughly half of the people who cited MHSP centers as their primary source of care formerly used private physicians. An additional 25 percent had come from public hospitals and clinics, 19 percent reported no previous regular source of care, and the remaining 7 percent had been regular users of other (private) hospital clinics. For whatever reasons, the MHSP was able to attract and keep patients who previously had used many different sources of medical care.

Staff at the Albert Witzke Medical Center in Baltimore have developed a program to improve communication between hearing-impaired patients and health care personnel. This program has received additional Foundation support.

Use of Health Services

Patterns of utilization of health services were compared for people living in the MHSP centers' service areas who used the centers and those who used other providers of care — particularly public hospitals and clinics and other (private) hospitals. In the majority of cities, the following findings applied.

- MHSP users, on average, had the highest rates of contact with primary care providers, usually physicians.[8]
- MHSP users had the lowest percentage of hospital admissions.
- Among people who were hospitalized, MHSP users had the lowest average number of days of hospitalization.
- MHSP users visited hospital emergency and outpatient departments less often.
- Dental services, which were available in every project, were not widely used. (However, according to HCFA sources, after 1982 there was a significant increase in the use of dental services by Medicare beneficiaries.)

Expenditures for Care

Estimates were made of spending for hospital, physician, and ancillary services for people using the MHSP and other sources of care.[9] Comparisons also were made of expenditures for Medicare and Medicaid beneficiaries who were MHSP users and nonusers. Analysis of these estimates revealed:

- Total annual expenditures for people using private hospital clinics were 28 percent higher than for MHSP users ($1,117 vs. $875). For people using private physicians, total expenditures were 11 percent higher ($969 vs. $875). However, total expenditures for MHSP users were 5 percent higher than those for users of public hospitals and clinics ($875 vs. $832). None of these differences, while generally favoring the MHSP, is statistically significant.
- Medicare's total annual expenditures for patients who used MHSP were 42 percent less than for those who used other sources of care ($989 vs. $1,705).
- Among Medicaid recipients, those who used MHSP had expenditures nine percent less than those who used other sources of care ($1,084 vs. $1,193), though this difference was not statistically significant.
- Because MHSP users in every city had the highest per capita number of physician visits, they also had the highest expenses in this category.
- Hospital expenditures were somewhat less for MHSP users than for most other groups, and emergency and outpatient expenditures were as much as 85 percent less for MHSP users.

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[7] Ginzberg E, Davis E and Ostow M. *Local Health Policy in Action: The Municipal Health Services Program.* Totowa, NJ: Rowman & Allanheld, 1985.

[8] Physician extenders did not have as strong an impact on MHSP utilization as had been forecast, in part because state certification requirements and practice codes for mid-level practitioners and low levels of reimbursement for their services did not support wider use of these personnel.

[9] Ancillary services refer to dental care, prescription drugs, laboratory services, and a variety of other services covered for MHSP users under the terms of the Medicare and Medicaid waivers.

than those of Medicare clients who used other sources of care. Overall, Medicare achieved significant savings under the program, due to substantial reductions in expenditures for hospital inpatient, outpatient, and emergency room services.

- Medicaid recipients who used MHSP centers received more covered services and appeared to have lower expenditures than did Medicaid clients who used other sources of care.
- MHSP's cost per patient visit declined substantially over the five years of the program, averaging 38 percent of the cost of a visit to a hospital emergency or outpatient department.
- MHSP centers have begun developing more sophisticated approaches for marketing their services to people of all income groups, especially through capitated, prepaid health plans.
- Most cities failed to achieve the goal of linking the community-based centers and the public hospital, which would have allowed center physicians to follow their hospitalized patients.
- Community hospitals, however, have shown unexpected interest in working with the MHSP projects and continue to do so.

Background

In 1977, The Robert Wood Johnson Foundation announced a program in which the nation's 50 largest cities would be eligible to compete for five grants aimed at improving and expanding community-based health services for people in underserved urban neighborhoods.

For many city-dwellers, emergency and outpatient departments of the public hospital had become the major source of primary care, usually at a cost of more than $100 per visit. At the time, urban public hospitals accounted for only 15 percent of all community hospitals, yet they delivered nearly 32 percent of all emergency and outpatient services.

The Municipal Health Services Program (MHSP) sought to create or expand networks of publicly owned and supported primary health care centers and to link these centers with public hospitals for back-up and referrals. In developing the MHSP, the Foundation and its advisors were mindful of the recommendation of the Commission on Public-General Hospitals that:

> The public-general hospital should play a major role in planning and arranging for neighborhood-based primary care services for community residents who do not have access to such care. . . . When backed up by the ancillary services and specialty referral capacity of the hospital, neighborhood-based services can encourage proper referrals to hospitals and discourage misuse of hospital emergency rooms.[1]

The program was to demonstrate whether large cities, through the cooperative efforts of leading elected officials, the health department, and the public hospital, could provide comprehensive medical care and a coordinated system of health care delivery by building upon existing public programs. Many large cities were hard-pressed financially and could not be expected to undertake health service initiatives that required heavy investments of capital and personnel. Consolidating and expanding existing resources, however, might avoid some of the pitfalls of federally sponsored health services programs of the 1960's, which ultimately left cities with the uncomfortable choice of letting these autonomous programs decline or shouldering their costs.

Because of the importance placed on the role of the mayors and local public health officials and on the role of the private medical community, the advice and assistance of the U.S. Conference of Mayors and the American Medical Association were sought from the program's initial planning stages.

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[1] The Commission on Public-General Hospitals. *The Future of the Public-General Hospital: An Agenda for Transition.* Chicago, Ill.: Hospital Research and Educational Trust, 1978. (The Commission was established in 1976 to study the future of the nation's 1,900 public-general hospitals. The Foundation helped support the study, which was sponsored by the Hospital Research and Educational Trust, an affiliate of the American Hospital Association.)

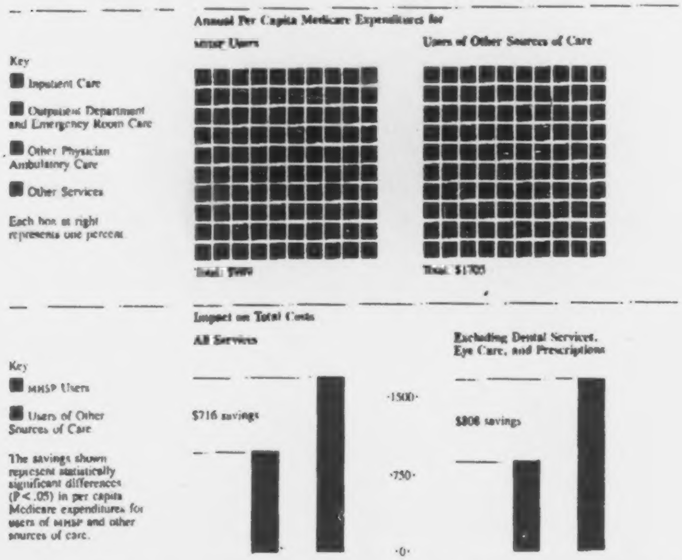
► Surprisingly, estimates for ancillary service expenses were not significantly higher for MHSP users than for other groups, even though the waivers liberalized Medicare and Medicaid coverage of these services.

These findings validate several important, related premises of the MHSP. As hoped, the MHSP's community-based primary care services substituted for costly emergency and outpatient department care. While expenditures for primary care services were higher for MHSP users, these increases were easily offset by decreased costs for ambulatory care provided by hospitals.

On balance, substantial Medicare savings on inpatient and hospital outpatient services (amounting to $1,045 per beneficiary per year) more than compensated for the $329 greater annual expenditures for physician and ancillary services (Figure 4). Ninety percent of Medicare expenditures for people not using MHSP were for hospital inpatient, outpatient, and emergency room care, compared to 50 percent for MHSP users.

Medicare's potential savings would be even greater if services not ordinarily covered had been excluded from the waiver. As it was, Medicare beneficiaries had available to them many more preventive and ancillary services — yet at a savings to the program.

Figure 4
Impact on Medicare Costs



NOTE: Data were adjusted for demographic, social, and health status differences between users of the MHSP and other sources of care.

SOURCE: Fleming GV and Andersen RA. The Municipal Health Services Program: Improving Medical Care Access while Containing Expenditures. August 1985, unpublished.

Chairman **Stark**. As I understand it, it is letting the hospital, the social work manager or the case manager for the people, decide what the people need as opposed to having it prescribed in law——

Ms. **Oakar**. That is right.

For example, if an older person is very frail and weak all the time, you might bring a dietitian in because one out of four people have anemia.

They may not need to be in a hospital, they might need a good nutritionist to tell them about their diet.

By the same token, they may need nursing home care if they break a hip for an interim period. That ought to be an option.

The problem is that CBO likes to estimate on a 1-year basis—we really ought to change that, but when you estimate on a 1-year basis without any proof, then you have to take their figures.

I think now since these pilot projects have been around for a while you really can demonstrate that it is cheaper.

Unfortunately, you have to look at that factor, but it is a factor.

You can also demonstrate that you can deal with a person's needs comprehensively and that is what long-term care is about. It is not just about nursing home care. It is about comprehensively dealing with a person's needs at what ought to be the golden years of his or her life.

Chairman **Stark**. Thank you very much.

[The statement of Ms. Oakar follows:]

Comments of

The Honorable Mary Rose Oakar

MR. CHAIRMAN AND DISTINGUISHED SUBCOMMITTEE MEMBERS:

THANK YOU FOR CONDUCTING THIS HEARING AND FOR YOUR COMMITMENT TO HEALTH CARE AND HEALTH DELIVERY FOR OUR PEOPLE. IT IS A PLEASURE TO TESTIFY BEFORE YOU.

I WOULD ALSO LIKE TO EXTEND A WARM WELCOME TO OUR COLLEAGUES FROM THE OTHER BODY. IT IS A PLEASURE TO HAVE YOU HERE OFFERING YOUR INSIGHTS INTO THIS ENORMOUSLY IMPORTANT ISSUE. IT IS MY SINCERE HOPE THAT WE WILL HAVE THE OPPORTUNITY TO WORK IN A CONFERENCE WITH YOU EARLY NEXT YEAR TO NEGOTIATE A LONG-TERM CARE BILL.

MR. CHAIRMAN, IT IS NOT OFTEN THAT WE AS MEMBERS OF CONGRESS RECEIVE THE OPPORTUNITY TO CORRECT LONG-STANDING INJUSTICES SUCH AS THE ISSUE WE ARE CONFRONTING TODAY. LONG-TERM HEALTH CARE COVERAGE IS AN ISSUE THAT HAS PLAGUED OUR PEOPLE FOR MANY GENERATIONS. OUR PARENTS HARBOR FEAR OF FINANCIAL RUIN AND THEIR CHILDREN WONDER HOW THEY WILL PAY FOR THE HEALTH CARE NEEDS OF TWO OR THREE GENERATIONS. OUR PEOPLE NEED HELP.

I HAVE BEEN A STUDENT OF THIS ISSUE FOR SOME TIME. AFTER A GREAT DEAL OF CONSIDERATION, AND AFTER WATCHING THE PERFORMANCE OF OTHER HEALTH CARE POLICIES, IT SEEMS TO ME THAT THE ONLY WAY TO EFFECTIVELY PROVIDE FOR THE LONG-TERM CARE NEEDS OF OUR PARENTS AND OUR PEOPLE, IS TO DO IT **COMPREHENSIVELY.** ANY OTHER APPROACH WILL ONLY ADD TO THE PIECE-MEAL, PATCHWORK OF PROGRAMS WE CURRENTLY POSSESS. IT IS TIME TO REALIZE THAT OUR PEOPLE DESERVE AND OUR NATION REQUIRES **COMPREHENSIVE LONG-TERM CARE.**

MR. CHAIRMAN, FOR THE LAST FOUR YEARS, I HAVE INTRODUCED A COMPREHENSIVE LONG-TERM CARE BILL THAT DESERVES CONSIDERATION. IT IS CENTERED AROUND THE PHILOSOPHY THAT ALL LONG-TERM HEALTH CARE NEEDS OF OUR NATION'S ELDERLY SHOULD BE MET IN A HOSPITAL-BASED AND COMMUNITY-BASED MANNER.

SPECIFICALLY, MY BILL, H.R. 679, CALLS FOR COMPLETE HOME-MAKING OR HOME-HELP SERVICES FOR THOSE WHO CAN RECEIVE THE CARE THEY NEED AT HOME; COMMUNITY-BASED MENTAL HEALTH SERVICES; ADULT DAY CARE OR DAY HOSPITAL SERVICES; CONGREGATE OR SUPPORTED HOUSING OR SHELTERED RESIDENTIAL CARE, AND; NURSING HOME SERVICES. IN ADDITION, MY BILL ALSO PROVIDES FOR APPROPRIATE SUPPORTIVE SERVICES FOR BENEFICIARIES INCLUDING CASE FINDING, PATIENT ASSESSMENT, PLACEMENT, MONITORING AND FOLLOW-UP AND QUALITY ASSURANCE, WITH RESPECT TO BOTH CONTRACTED AND PROGRAM-BASED SERVICES.

MY BILL WORKS IN THE FOLLOWING WAY: H.R. 679 BILL WOULD ENABLE MEDICARE TO CONTRACT WITH "HOSPITAL-BASED" COMPREHENSIVE CARE PROGRAMS TO OFFER TO "RELATIVELY FRAIL" MEDICARE BENEFICIARIES A PACKAGE OF COMPREHENSIVE CARE BENEFITS. MEDICARE WOULD PAY THE CONTRACTING HMO A PREMIUM NO MORE THAN 95% OF THE AVERAGE ADJUSTED PER CAPITA (AAPC) COST OF MEDICARE BENEFITS IN THE FEE-FOR-SERVICE SECTOR. THIS PREMIUM IS ALLOWED TO BE BASED ON AN AAPC COST WHICH WOULD BE SOMEWHAT HIGHER THAN THE CURRENT PREMIUM IN ORDER TO REFLECT THE "RELATIVE FRAILTY" OF THE ENROLLED GROUP.

THIS KIND OF COMPREHENSIVE CARE MAKES GOOD SENSE. IT ALLOWS FOR A DIGNIFIED LIFE FOR MEDICARE BENEFICIARIES, THE REMOVAL OF FINANCIAL INSTABILITY FOR THEIR CHILDREN, AND FOR TAKING A GIANT STEP TOWARD FULFILLMENT OF THE AMERICAN DREAM.

MR. CHAIRMAN, THERE IS YET ANOTHER REASON FOR CREATING A COMPREHENSIVE LONG-TERM CARE SYSTEM; NAMELY, BOTH PRESIDENTIAL CANDIDATES HAVE PUBLICLY STATED THAT THEY INTEND TO LEAD OUR NATION INTO A TIME OF INVESTMENT AND SAVINGS. I STRONGLY SUPPORT THEIR INTENTIONS. IF THIS IS THE FUTURE WE CAN EXPECT, I BELIEVE A STRONG CASE CAN BE MADE STATING THAT INVESTMENT IN HEALTH CARE IS ONE OF THE SMARTEST POLICIES WE CAN MAKE.

MANY NATIONAL POLLS STATE THAT THE AMERICAN PEOPLE BELIEVE THAT INVESTING IN HUMAN RESOURCES, SUCH AS HEALTH CARE AND EDUCATION, ARE CRITICAL FOR A STRONG AMERICA. PROVIDING COMPREHENSIVE HEALTH CARE FOR OUR POPULATION ENABLES US TO COMPETE INTERNATIONALLY FOR A SECURE FUTURE. WE MUST CONTINUE TO LEAD THE WORLD, AND THE ONLY WAY TO ACCOMPLISH THAT GOAL IS TO PROVIDE FOR A HEALTHY POPULATION CAPABLE OF PROVIDING THAT LEADERSHIP.

MR. CHAIRMAN, AS I HAVE STRONGLY STATED, WE MUST HAVE A COMPREHENSIVE LONG-TERM HEALTH CARE PROGRAM FOR OUR PEOPLE. HOWEVER, IF, AFTER A GREAT DEAL OF STUDY YOU AND THE MEMBERS OF THIS DISTINGUISHED SUBCOMMITTEE AND COMMITTEE DO NOT FEEL IT IS POSSIBLE FOR US TO CREATE SUCH A PROGRAM, I STRONGLY RECOMMEND THE CREATION OF A COMPROMISE SYSTEM CENTERED AROUND THE STRUCTURE OF THE LONG-TERM CARE BILL WE CONSIDERED LAST JUNE. CHAIRMAN PEPPER AND CHAIRMAN ROYBAL'S BILL REPRESENTS THE MOST HEART-FELT DESIRES OF OUR PEOPLE. THE VAST MAJORITY OF AMERICANS WANT TO STAY AT HOME DURING THEIR LONG-TERM ILLNESSES INSTEAD OF BEING CAST INTO AN INSTITUTION. THE EXPENSES ADDRESSED IN THE PEPPER'ROYBAL BILL ACCOUNT FOR AT LEAST 50% OF LONG-TERM CARE COSTS AND FORM THE MOST FINANCIALLY DEVASTATING PORTION OF LONG-TERM CARE. WE SHOULD PROVIDE FOR OTHER ASPECTS OF LONG-TERM CARE -- SUCH AS NURSING HOME EXPENSES -- ONLY **AFTER** WE PROVIDE FOR HOME CARE SERVICES.

IN ADDITION TO PROVIDING THE TYPE OF LONG-TERM CARE OUR PEOPLE WANT, WE SHOULD BE MINDFUL THAT OUR PEOPLE ARE DEMANDING A GENERAL RESOLUTION TO THE LONG-TERM CARE CRISIS. NATIONAL POLLS CLEARLY STATE THAT AMERICANS WANT AND NEED HELP WITH LONG-TERM CARE EXPENSES. ONE POLL, CONDUCTED FOR THE AARP AND VILLERS FOUNDATION STATE THAT FULLY **90% OF THE AMERICAN PUBLIC SUPPORTS LONG-TERM CARE LEGISLATION IN SPITE OF THE FACT THAT IT MAY COST THEM MORE IN TAXES, PREMIUMS, OR OTHER COSTS.** THIS FIGURE IS A VERY IMPRESSIVE STATISTIC WE SHOULD NOT IGNORE.

MR. CHAIRMAN, WE SHOULD HONOR THE WISHES OF OUR PARENTS, AND PROVIDE FOR THEM DURING THEIR TIME OF NEED. IN LIGHT OF ALL THEY HAVE GIVEN US DURING THEIR LIFETIMES, THIS IS THE LEAST WE CAN DO FOR THEM. AFTER ALL, WE MUST KEEP IN MIND THAT THE PEOPLE WHO NEED THE MOST CARE ARE THE PEOPLE WHO MADE THIS NATION GREAT. THEY ARE THE PEOPLE WHO FOUGHT IN WORLD WAR ONE AND WORLD WAR TWO. THEY ARE THE PEOPLE WHO STRUGGLED AND SURVIVED THE GREAT DEPRESSION. THEY ARE ALSO THE PEOPLE WHO HAVE PROVIDED FOR OUR WELL-BEING WHEN WE WERE GROWING UP. TO DENY THEM THE CARE THEY NEED WOULD BE A NATIONAL DISGRACE.

MR. CHAIRMAN, I URGE YOU TO MOVE SWIFTLY TO PASS OUT OF COMMITTEE A BILL THAT WILL INVEST IN THE HEALTH CARE OF OUR PEOPLE. WE NEED TO PROVIDE COMPREHENSIVE LONG-TERM CARE THAT MAKES PROVISIONS FOR HOME HEALTH CARE, NURSING HOME CARE, COMMUNITY-BASED MENTAL HEALTH CARE, ADULT DAY CARE, AND CONGREGATE OR SUPPORTED HOUSING OR SHELTERED RESIDENTIAL CARE. IT IS IMPORTANT TO BUILD UPON THE HARD WORK THAT HAS BEGUN UNDER CHAIRMEN PEPPER AND ROYBAL. WE SHOULD GIVE THE PEOPLE WHAT THEY CLEARLY WANT AND DESERVE.

THANK YOU.

Chairman **Stark**. Mr. Donnelly.

Mr. **Donnelly**. I have two questions, Mr. Chairman.

One, do you have any objection to income-relating any expansion of Medicare to long-term care; in other words, taking into account people's ability to pay?

Ms. **Oakar**. If this is going to get your vote for my bill—I really do, because the moderate-to-middle-income poor—I call them the sort of near-poor people—are never counted in anything.

These are people that worked all their lives and so they get $20,000 or $30,000 in their sort of net worth. That is not a lot of money when you consider the other avenues of costs that they have in their lives.

I don't like means testing unless you really have to.

I understand what you had to do with the catastrophic bill and so on, but philosophically, I am opposed to it on its face value.

If you get into a particular bill, I like to view this on a case-by-case basis.

Mr. **Donnelly**. As a followup to that, this is more generic, ought we to factor in the children's responsibility to their parents, financial responsibility to the parents, or ought we just proceed ahead with expansion of the program and fund it some other way?

Isn't there some sibling responsibility?

A long-term case benefit would, in fact, protect assets that will eventually go to some or all of the children.

Ms. **Oakar**. You know, I wish that all older people had children who, No. 1, cared about them or were around for them.

The fact is that the average 70-year old woman, to be 70 years old, to be female, is to be alone pretty much, and poor.

The fact is that while we would love to see more of a responsibility on the part of those children who could afford it to take some of the burden, I don't think that that exists all of the time.

So it is so hard to pinpoint these kids. They are restricted as it is right now.

For example, if a child wants to take in a parent who is on SSI, the parent loses the SSI—we do all the things the wrong way.

Instead of giving that kid incentive to put the parent up decently, we take away the benefit if they have another avenue from which to work, so I am not sure you can do that across the board to begin with.

Second, there are many children who really are trying to care for their parents.

It is not only a burden on them financially, but psychologically, they don't have the means, the tools, the services to work with——

Mr. **Donnelly**. Why couldn't we build in a reward for those types of people that are taking care of their parents?

On the other hand, those that won't take responsibility, deal with that through changes in the estate tax. Otherwise, any long-term care benefit will protect those assets that are going to the children that are either responsible or irresponsible; we would treat them the same way.

Ms. **Oakar**. I think it would be nice to try to do that, and I know ideally there ought to be that kind of connection or linkage, but I don't really feel making this some kind of a dependent care means-tested program is the answer.

If you have some examples of how you can provide long-term care cheaper and with more quality and more comprehensiveness, why not start with that as a base?

Chairman **Stark**. Thank you very much.

Ms. **Oakar**. Thank you, Mr. Chairman.

Chairman **Stark**. Our next witness is the Honorable George Mitchell, joined by the Honorable Dave Durenberger.

Senator Mitchell has sponsored S. 2305, which is roaring down the legislative track in the U.S. Senate. I am sure that he is being ably assisted in that endeavor by Senator Durenberger. I have followed Senator Mitchell's work in this area and I think I can say he has one of the most comprehensive approaches to the entire problem of long-term care.

We welcome both of you here. We are honored to have you with our committee.

If you have prepared statements, we will include them in the record without objection in their entirety. I will ask you to proceed in any manner that you are comfortable with and to leave us time for questions.

We appreciate your being here.

Senator **Mitchell**. Thank you very much, Mr. Chairman.

STATEMENT OF HON. GEORGE J. MITCHELL, A U.S. SENATOR FROM THE STATE OF MAINE

Senator **Mitchell**. My thanks to you and all the members of the committee for permitting us to appear here today to discuss what is one of the most serious health care issues in our Nation today: the need for a rational and coordinated long-term care policy in this country.

I will ask, with the chairman's consent, that my full statement be placed in the record, and I will speak briefly extemporaneously and then defer to my colleague and hopefully have a dialog after.

Chairman **Stark**. Without objection.

Senator **Mitchell**. Mr. Chairman, you and members of the committee, along with Senator Durenberger and I, participated in the recent enactment of the Medicare Catastrophic Act. That was a significant accomplishment in which we can all justifiably take pride.

We all recognize that we have yet to deal with what is in reality a most serious source of catastrophic health expense to the elderly, and that is long-term care; 80 percent of out-of-pocket health care costs borne by the elderly and their families are the costs of chronic illness. Unfortunately it is often only when a person faces placement in a nursing home that he or she learns for the first time the costs of such services are not covered under Medicare.

The reality is that we as a nation do not have a long-term care policy. Services to the elderly to provide long-term care are not coordinated or adequately financed. Most elderly persons who receive nursing home care must either be wealthy enough to pay for the care themselves or be forced to impoverish themselves to become Medicaid eligible.

As you indicated in your kind introduction, earlier this year I introduced the Long-Term Care Assistance Act of 1988. I look forward to working with you and other members of the committee in enacting legislation in this area, hopefully in the very near future.

My legislation is intended to provide the least restrictive and most cost effective care possible. It will provide greater opportunity for the elderly to remain in their homes as long as possible.

This past May I received testimony in a hearing that confirmed what our instincts told us, that is, that there are literally thousands of people in this country who are today receiving a level of care that is higher and much more expensive than they need or want.

Reimbursement policies are driving medical decisions. As a consequence, at this very moment I am confident that in a hospital close to where we are sitting and in a hospital in every State represented here, there are elderly persons in acute care beds, the most expensive form of treatment, who would be better served in nursing homes at much less expense. But they cannot get into nursing homes because they are full. One of the reasons they are full is there are many people in the nursing home beds who would be better served at home, and less expensively. They are not at home because some types of home care are not reimbursable, whereas nursing homes are.

Not only are we not providing the care best suited to the individual, we are wasting billions of dollars. A recent survey came to my attention yesterday. Maine hospitals indicated that, as of the survey date, 6 percent of the persons hospitalized were awaiting discharge to long-term care facilities but were remaining in the acute care beds because no alternative was available. That represented 200 people.

The aggregate number of dates that they had been waiting, that is, when they were medically eligible for discharge but had no alternative place to go, was 22,000 days. This is in a State with just over 1 million people. Imagine what those figures would be extrapolated across the country.

So what I am suggesting, Mr. Chairman, is that a long-term care policy such as that embodied in my legislation, which provides the full range of services, would drain from the system reimbursement policies as a factor in medical placement decisions and enable people to receive the quality of care best suited to their individual needs and probably at less expense.

Now, that would be offset by the increase in expense by the so-called woodworking effect, that is, when the benefit becomes available, more people will take advantage of it. So I don't want to say it is all going to be a reduction.

My bill would not add to the deficit because it is self-financed by three types of taxes, which I will be glad to describe in detail in the question and answer period.

I don't suggest that my bill is the only answer or even the best answer. It is an answer that I hope will stimulate the kind of discussion that this hearing represents and lead us to enact what is long overdue: a meaningful long-term care policy that has always been essential but is now critical, given the demographic revolution now sweeping our nation.

When people live in the midst of a great historical event, they are often unaware of its full implications. We are living in the midst of such an event now, and that is the lengthening of the lifespan of the American population. It presents an enormous opportunity, a challenge, and unless dealt with properly, a serious problem.

This is a problem, one that we have to deal with, and I hope we will do so soon. I look forward to working with you and with my colleague, Senator Durenberger, who has done so much in the area of health care over the last several years.

Chairman STARK. Thank you.

[The prepared statement follows:]

PREPARED STATEMENT OF HON. GEORGE J. MITCHELL, A U.S. SENATOR FROM THE STATE OF MAINE

Mr. Chairman, I appreciate the opportunity to speak before the Subcommittee today to address a critical issue facing all of us—the need for a rational and coordinated long term care policy in this country.

We have recently enacted the most significant expansion of the Medicare program since its inception—the Medicare Catastrophic Coverage Act. While we can justifiably be proud of this accomplishment, we have not begun to address what is, in reality, the most catastrophic illness for the elderly—long term care.

Eighty percent of out-of-pocket health care costs borne by the elderly and their families are the costs of a chronic illness. It is often only when a person is facing placement in a nursing home that he or she learns that the costs of such long term care services are not covered under Medicare.

We as a nation are growing older. As the population ages, particularly beyond the age of 85, the need for long term care for chronic illness dramatically increases.

Long term care includes a range of services provided to those in our society who suffer from chronic illnesses, and cannot function independently. While the range of appropriate services varies with the degree of disability, many elderly persons in need of care do not have access to those services most appropriate for their needs.

Access to appropriate services is limited because of limited financial support and inadequate coordination.

The reality is that we as a nation do not have a long term care policy. The services that are available to the elderly to provide long term care are in no way coordinated or adequately financed. Most elderly persons who require nursing home care must either be wealthy enough to pay for that care themselves, or are forced to impoverish themselves to become Medicaid-eligible.

Earlier this year I introduced the Long Term Care Assistance Act of 1988, S. 2305. This legislation is intended as a serious attempt at beginning a national dialogue on the delivery and the financing of long term care.

This bill is not a panacea. It is not intended as the final solution to the problem of financing long term care benefits. It is, rather, a sincere effort to reform the way long term care services are delivered and paid for.

The bill provides a new Medicare benefit for long term care, and will include services along a continuum from occasional respite care to full institutionalization. The bill will be self-financed and will not add to the federal deficit in any way.

First, the bill is designed to provide the least restrictive and most cost-effective care possible, and is intended to provide greater opportunity for the elderly to remain in their homes whenever possible.

Eighty percent of long term care is provided informally—by family caregivers. This bill recognizes and supports the important role of the informal caregiver by including a respite care benefit, with services provided either in the home or in an adult day care setting.

Secondly, the bill provides a new and more expansive home care benefit which will be available for chronic home care services, including homemaker and chore aid benefits.

Thirdly, nursing home benefits would be available to those beneficiaries who qualify for chronic nursing home services. Medicare would begin to reimburse for these costs after a two-year exclusionary period.

As a means of utilization control, this legislation imposes copayments and deductibles for its benefits.

All of these new benefits will be available to Medicare beneficiaries who are determined to be eligible by an assessment and certification process based on functional and/or cognitive limitations.

The coordination of these benefits through a case management system is a critical component of this legislation. Several states have implemented case management systems which may serve as models for the development of a national system. I am working with a number of experts throughout the country to further develop the case management piece of this bill and look forward to working with you and your staff on this vital component of a long term care system.

The exclusionary period for the nursing home benefit has been the subject of much debate during the past year. There are some who do not support this concept, and others who believe a public-private partnership for long term care is the only feasible way to design a program.

We have reason to believe that the insurance industry will respond to the need for long term care insurance with the development of new policies to meet the needs of our aging population. We hope that the development of a fixed insurance premium will enable middle income elderly to protect their savings through the purchase of long-term care insurance policies so that they do not have to impoverish themselves as is currently the case.

I have proposed three sources of revenue for this bill.

First, the elderly would finance part of the program through a modest increase in the Part B premium.

Second, the Medicare wage cap, which in 1988 exempts wages above $45,000 from the 1.45 percent Medicare Hospital Insurance tax, would be repealed.

Finally, a 5 percent surtax would be imposed on transfers by gift or inheritance of assets in excess of $200,00. Current law exempts estate and gift transfers of less than $600,000 by applying a unified credit against tax liability. This proposed surtax would be imposed after the unified credit is taken so that transfers with a value between $200,000 and $600,000 would be taxed.

This legislation would raise the revenues necessary to fund the new long-term care program benefits. It will therefore, be subject to attack by those who object to any increased revenue. However, it should be understood that this legislation will not increase national expenditures on long-term care. It will, rather, provide for a fairer, more certain way of funding those expenditures. It will remove the financial threat hanging over American families.

Because of the important role of private insurance, it is important to clarify a number of issues in current law with respect to the tax treatment of long-term care insurance. Therefore, the bill includes a number of Internal Revenue Code changes to clarify that long-term care insurance is generally to be treated for tax purposes the same as accident or health care insurance.

The lack of a current long term care policy results in unfairness to many American families. In the next thirty years the situation will get worse, unless we now come to grips with the problem. We need a coordinated effort, drawing on the resources of the public and private sectors. We need to prefund future liabilities in the private sector through insurance and in the public sector through the development of a fund dedicated to long term care. This bill provides an opportunity for public and private cooperation to meet an important social goal.

It is important that it be clearly understood what this proposal is, and what it is not.

It is not a comprehensive public program to provide reimbursement for all services received. It is, rather, in its public aspect, intended to protect American families against the catastrophic cost of very long term care. It is, in short, a form of public insurance policy against the extraordinary expense of very long term care that will be incurred by a minority of elderly Americans who cannot be identified in advance.

It is, of course, an individual judgment as to where the proper balance lies. This bill represents my judgment. I understand that others will reach different conclusions on that question and respect those views and look forward to further debate and discussion on this central concern.

Chairman STARK. Let's hear from Senator Durenberger and perhaps we can inquire of both of you on this problem.

We will include your prepared statement in the record, Senator Durenberger, and ask you to proceed in any manner you are comfortable with.

STATEMENT OF HON. DAVE DURENBERGER, A U.S. SENATOR FROM THE STATE OF MINNESOTA

Senator **Durenberger**. Mr. Chairman, I would like to have my statement introduced in the record and printed in full.

It is nice to see Jim Moody back. I regret that Jim is sitting up here and not campaigning in Wisconsin.

I would like to talk today about the need, and not so much the specifics, but maybe some set of principles that might guide us in our efforts to redesign the Nation's health care and insurance system so we can provide a continuum of care for anyone who is severely ill or disabled.

Let me start with one of these charts that, in my generational equity days, I liked to carry around.

These are the demographics. The big green pie carries you from the year 1900, when there were less than 3 million Americans over the age of 65, through 2040, when there will be something in excess of 65 million Americans over 65 years of age.

The more dramatic one is the Vikings color here, less than 100,000 people over the age of 85 at the beginning of this century and here my dad was born in the beginning of the century. From the time my father was born to the time my youngest son reaches my father's age today—a span of three generations—the over 65 will go from 3 million to 65 million, and the over 85 will go from 100,000 to nearly 13 million.

Long-term care is not only for the elderly. In fact, long-term care is needed for all age groups, for children with disabilities and birth defects, and for young men with devastating spinal cord injuries. Traumatic head and spinal cord injuries result from automobile accidents, motorcycle injuries, even falls from bicycles.

The goals of health care policy must be to improve access to care, but access will be increasingly limited if we do not reduce the rapid escalation of health care costs.

From 1966 to 1980 the cost of Medicare and Medicaid doubled every 4 years. Medicare outlays alone went from $7 billion in 1970 to $35 billion in 1980 to $70 billion in 1987. Medicare has doubled in the Reagan years, in spite of relatively successful efforts to bring part A outlays well below double-digit increases and despite the fact that defense gets all of the credit for spending increases.

As a young man, I remember visiting my grandmother in her nineties in a rest home. Later the same facility became a nursing home. Then it became either a skilled nursing facility—SNF—or an intermediate care facility—ICF. Today as I visit hundreds of communities in rural Minnesota, I cannot tell the difference between a hospital and the nursing home in terms of patient condition. The condition of the patients is very similar, but one has a surgery center.

Despite all of this public spending that is going into institutional care, as illustrated by the chart on Minnesota, the predominance of caregiving is still done by the family, in private homes. Only about 21 percent of the disabled elderly were in nursing homes in 1985. Even of those with the most severe disabilities, less than half of the elderly disabled were in nursing homes. An estimate 27 million unpaid days of care are provided each week in the United States.

Nursing home care consumes about 88 percent of public expenditures for LTC.

As to progress to date, together we are making remarkable progress in dealing with the problems of uncontrolled cost escalation and an anachronistic payment system, which has not kept up with the needs or capabilities of service providers.

During the 98th, 99th and 100th Congresses, we have made significant, positive redirection in the Nation's income security system. We have made dramatic changes in income tax rates and brackets. We have brought down the 35 percent inflation adjustment in 1978 to 1980 to an amount 6 percent less than that over the last 7 years.

During this very special year together, we have added catastrophic health insurance to Medicare; we have begun to change 23 years of medical benefits to include prevention benefits; we have begun some long-term-care benefits with respite coverage and home health care expansion; we have ended spousal impoverishment; we have introduced premium financing of new benefits and income-related the new premium; we have substantially advanced the cause of maternal and child health; we have started down the road to real welfare reform and substituted earnings supplement.

I believe we are clearing the way for substantial redesign of health care financing and the future of long-term care in this country.

Our objective in long-term care must be the same as our objective in acute care reform: that every American is entitled to the same opportunity that you and I have to carry a plastic card which is his or her membership in a health plan providing access to health and wellness benefits.

Only the way in which we finance and provide choice of those plans remains open. I want to leave you with a set of principles, rather than a set of proposals. These are principles that I use as guides during health system reform. These are measures of what we should look for and to check whether we are on the right path through this very difficult terrain.

First, choices are good and Government policy should expand options to the individual, not limit them. There should also be incentives for selection of cost effective services.

Second, Government is generally a better purchaser or financer of services than a direct provider. The Federal Government has incredible power as a purchaser. It should use that to give incentives for economy and efficiency.

Third, Government should be a source of research on outcomes and quality both to improve consumers' knowledge of choices and to make certain that Government is a smart buyer.

Fourth, the price of goods or services should be a true measure of its cost. Subsidies by the public sector should be explicit.

Fifth, Government should guarantee access to necessary care. But access must be paid for and the standards which are guaranteed must be realistic. We also have to grapple with the tough question of access to what. A continuum of care should place emphasis on prevention, primary care, home care, rehabilitation, rather than institutional care.

Sixth, cost sharing is desirable.

Seventh, there will be changes in service needs and fluctuations in need and capacity. The health system must be able and willing to adapt to such changes. We will never find the resources for all essential care if the system overall is not more productive. We must have productivity increases to help us finance an aging society, meet the still unmet needs and pay for the new technology.

Eighth, the Government should help us establish guidelines through research for quality of care and effectiveness. It must also expedite the transmission of quality information as it has through the NIH consensus development conferences, but the ultimate judge of quality will be the consumer, patient and patient's family.

Ninth, the government subsidies should go to the consumer, not the provider, and should be targeted to those with the greatest need.

Tenth, related to all of this is that whatever we do, we must build in ways to properly manage costs, reducing the escalation in health care costs which is plaguing the Nation and could stop any progress toward more comprehensive coverage. I believe that proper care management, based on the most effective sequencing of care—which often means higher quality and even higher front-end costs—can pay high dividends in long-term benefits and lower overall costs. This is best seen in the field of rehabilitation.

Eleventh, national tax and income policy must reflect our values of personal responsibility for investing current income through savings, investment and insurance in long-term care protection.

Mr. Chairman, as we work together to finance a new system of benefits, we must build in consumer protection and quality assurance, care management, cost escalation controls, continuum of services, case flexibility, cost sharing for those who can afford it and complete coverage for those who cannot afford it.

Mr. Chairman, you and I, I am proud to note, seem to share a well-kept secret, that is, while we are designing a comprehensive long-term care social insurance system, we need also to be certain that shoddy products and scary abusive marketing practices are stopped before harm is done in the long-term care insurance area. We have almost identical bills to protect consumers.

I believe this is one critical piece of legislation that we can both get enacted this year. With your great influence in the House and my working with my cosponsors and colleagues, I believe we can have the Stark-Durenberger bill signed into law soon.

This has been a great year for working together—on catastrophic coverage, on respite care, on screening mammograms, prescription drugs and maternal and infant care for poor women and children. We have time for one more important piece of consumer protection legislation. I am eager to work with you to make this happen before we adjourn.

Mr. Chairman, I would close simply by saying that while this is all hopefully something we will get at next year, there is one thing we can do this year which you are on top of and I am on your side, and that is the design of a consumer protection insurance bill for long-term care.

We are not getting a lot of support for our bills right now because there have not been a great number of scandals. When there are, they will look for the Stark-Durenberger bills.

[The statement of Senator Durenberger follows:]

STATEMENT OF SENATOR DAVE DURENBERGER

Mr. Chairman, thank you for holding this important and timely hearing. Like you, Senator Pepper, Senator Mitchell and others, I am committed to redesigning the Nation's Health Insurance Systems to provide a continuum of care for anyone who is severely ill or disabled. I want to tear down artificial or anachronistic barriers to effective care. I want to obliterate increasingly meaningless categories that hurt or anger people who are in pain or in need and who want their government to be a part of the solution, not be a part of the problem.

I want that system to be available to all Americans--building on social insurance principles, without bureaucratic, counterproductive impediments to the most appropriate level of care. We must act now. We already have great need but the problems will explode in the future. You can see by the chart (A) what is happening to the aging of our population from the 1900's to the year 2040. The percentage of United States Population which is 65 years old and older will go from 2% in 1900 to 4.2% in 2040. From the time my father was born to the time my youngest son reaches my father's age today--a span of three generations--the over 65 will go from 3 million to 65 million and the over 85 will go from 100,000 to nearly 13 million.

Long term care is not only for the elderly. In fact, long term care is needed for all age groups, for children with diabilities and birth defects, and for young men with devastating spinal cord injuries.

Traumatic head and spinal cord injuries result from automobile accidents, motorcycle injuries, even falls from bicycles. The goals of health care policy must be to improve access to care but access will be increasingly limited if we do not reduce the rapid escalation of health care costs.

From 1966 to 1980, the cost of medicare and medicaid doubled every four years(!). Medicare outlays alone went from $7 billion in 1970 to $35 billion in 1980 to $70 billion in 1987. Medicare has doubled in the Reagan years, in spite of relatively successful efforts to bring part a outlays well below double digit increases and despite the fact that defense gets all of the credit for spending increases.

As a young man I remember visiting my grandmother in her nineties in a rest home. Later the same facility became a nursing home. Then it became either a skilled nursing facility (SNF) or an intermediate care facility (ICF).

Today, as I visit hundreds of communities in rural Minnesota, I cannot tell the difference between a hospital and the nursing home in terms of patient condition. The condition of the patients is very similar but one has a surgery center.

Despite all of this public spending that is going into institutional care, as illustrated by the chart on Minnesota, the predominance of care giving is still done by the family, in private homes.

Only about 21% of the disabled elderly were in nursing homes in 1985. Even of those with the most severe disabilities, less than half of the elderly disabled were in nursing homes. An estimated 27 million unpaid days of care are provided each week in the United States. (Rivlin and Wiener, 1988), but nursing home expenditures dominate long term care financing. In 1987 dollars, it is estimated that an average of $33 billion dollars per year will be spent on nursing home care for the elderly betweeen 1986-1990.

As shown in my chart, (B) nursing home care consumes about 88% of public expenditures for long term care.

I chose this afternoon not to talk about specific bills--even my own which now number 5- but to applaud our joint efforts particularly between our leaders, Senator Mitchell and Senator Bentsen, and the Senate Finance Committee, the House Ways and Means and Energy and Commerce Committees. Together we are making remarkable progress in dealing with the problems of uncontrolled cost escalation and an anachronistic payment system, which has not kept up with the needs or capabilities of service providers.

During the 98th, 99th and 100th Congress, we have made significant, positive redirection in the nation's income security system. During this very special year together,

We have made dramatic changes in income tax rates and brackets.
We have brought down the 35% inflation adjustment in 1978-80 to an amount much less (29%) than that over the last 7 years.
We have added catastrophic health insurance to Medicare,
We have begun to change 23 years of medical benefits to include prevention benefits;
We have begun some "long term care" benefits with respite coverage and home health care expansion;
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We have introduced premium financing of new benefits and income related the new premium;
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I believe we are clearing the way for substantial redesign of health care financing and the future of long term care in this country. Our objective in long term care must be the same as our objective in acute care reform. That every American is entitled to the same opportunity that you and I have to carry a plastic card which is his or her membership in a health plan providing access to health and wellness benefits.

Only the way in which we finance and provide choice of those plans remains open. I want to leave you with a set of principles rather than a set of proposals. These are principles that I use as guides during health system reform. These are measures of what we should look for and to check whether we are on the right path through this very difficult terrain.

The overarching goal of my redesign of medicare would be to ensure every American access to the needed continuum of care. For the elderly, the disabled, the impaired children, every effort would be made to guarantee that services would be available to keep or help each person be as independent as possible.

First, choices are good and government policy should expand options to the individual, not limit them. There should also be incentives for selection of cost-effective services.

Second, government is generally a better purchaser or financer of services than a direct provider. The federal government has incredible power as a purchaser. It should use that to give incentives for economy and efficiency.

Third, government should be a source of research on outcomes and quality both to improve consumer's knowledge of choices and to make certain that government is a smart buyer.

Fourth, the price of goods or service should be a true measure of its cost. subsidies by the public sector should be explicit.

Fifth, government should guarantee access to necessary care. But, access must be paid for and the standards which are guaranteed must be realistic. We also have to grapple with the tough question of access to what. A continuum of care should place emphasis on prevention, primary care, home care, rehabilitation, rather than institutional care.

Sixth, cost sharing is desirable.

Seventh, there will be changes in service needs and fluctuations in need and capacity. The health system must be able and willing to adapt to such changes.

We will never find the resources for all essential care if the system overall is not more productive. We must have productivity increases to help us finance an aging society, meet the still unmet needs and pay for the new technology.

Eighth, the government should help us establish guidelines through research for quality of care and effectiveness. It must also expedite the transmission of quality information as it has through the National Institutes of Health (NIH) consensus development conferences but the ultimate judge of quality will be the consumer, patient and patient's families.

Ninth, government subsidies should go to the consumer not the provider and should be targeted to those with the greatest need.

Tenth, related to all of this is that whatever we do we must build-in ways to properly manage costs--reducing the escalation in health care costs which is plaguing the nation and could stop any progress toward more comprehensive coverage.

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This is best seen in the field of rehabilitation.

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Mr. Chairman as we work together to finance a new system of Benefits, we must build-in:

Consumer protection and quality assurance
Care management cost escalation controls
Continuum of services
Case flexibility
Cost sharing for those who can afford it
Complete coverage for those who cannot afford it

Mr. Chairman, you and I, I am proud to note, seem to share a well kept secret that is while we are designing a comprehensive long term care, social insurance system, we need also to be certain that shoddy products and scarey abusive marketing practices are stopped before harm is done in the long term care insurance area. We have almost identical bills to protect consumers.

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With your great influence in the house and my working with my cosponsers and colleagues, I believe we can have the Stark-Durenberger bill signed into law soon.

This has been a great year for working together--on catastrophic coverage, on respite care, on screening mammograms prescription drugs and maternal and infant care for poor women and children.

We have time for one more important piece of consumer protection legislation. I am eager to work with you to make this happen before we adjourn. Thank you again.

Chairman **Stark**. Maybe we can get a few cosponsors today.

Senator **Durenberger**. Maybe I can get George to get on mine and it will be a fait accompli.

Chairman **Stark**. I notice you used those same charts for cranberry subsidies.

Senator **Durenberger**. Mr. Chairman, let me say I appreciate what you are doing on the consumer protection bill. I hope we can find a way to pass it.

Chairman **Stark**. Senator Mitchell, could you comment on the revenue, the size of the revenue you think we could raise out of the estate income tax, in round numbers?

Also, I know you were troubled by the 2-year waiting period. Do you have any revenue figures on what they would drop it in 1 year?

Third, do you still think we can have income-related premiums to pay for long-term care?

Senator **Mitchell**. If I can respond in reverse order, the answer is yes. It is going to be next year when the premium is paid, as opposed to the one described, where the people will experience it more than read about it.

I believe it is like many similar important social changes, so necessary and justifiable that we will be able to do so, and I think that it is important as a way of forestalling other more significant changes which I personally oppose, such as direct means testing of benefits, for other reasons.

Now, the three tax provisions which are included in my legislation are: first, a modest addition to the premium paid for beneficiaries, as the catastrophic bill has, would be paid by the flat premiums and have supplemental income based; an estate tax surcharge of 5 percent, that would be a surcharge of 5 percent on those estates which are now subject to tax, that is above $600,000 after the application of unified credit. But those estates between $200,000 and $600,000 would of course have a tax. They are not now taxed, so it could not be accurately described as a surtax. I am advised by my staff that will be expected to raise approximately three to $4 billion a year. The final item is the removal of the wage cap for the health insurance portion of the Social Security tax.

Now, I have to say to you that when we prepared the legislation for introduction, we did not have the cost estimates on the home health portion of the legislation. Those have come in substantially higher than anticipated.

It is my initial reaction that the estimates I have received on my bill are irreconcilable with the estimates provided to Senator Pepper on his home care bill because, although the coverage under mine is far less expansive, the estimate is over 50 percent of what his was.

I am going to ask CBO for some explanation. Either his is too high or yours is too low. Ours is 8 and his is 15. We just got these figures and I am not certain that these revenues from the taxes I described would meet the current estimates of cost.

Chairman **Stark**. Yours was 15 and Mr. Pepper's was 8?

Senator **Mitchell**. No; the reverse. His provided broader home care coverage and it was estimated at $15 billion.

When I saw that I estimated ours would come in at about a third, not more than half—there may be good and valid reasons for it. The reason I point that out is to make clear that at the time I introduced the legislation and included the revenue provisions in the bill, the three I just described, we did not have final cost estimates, so there may have to be some revisions either to reduce the cost or of revenues to meet the expenditures.

Chairman STARK. Could you give us an aggregate idea of the cost of moving from the 2-year waiting period to the 1? Do you have any numbers on that?

Senator MITCHELL. My recollection is that it nearly doubled the cost of that provision—$10 billion a year, according to staff—to go from 2 to 1, once fully implemented. That was the most difficult decision to make. It has been the subject of the most controversy and criticism for this 2-year period.

I included it for two reasons. The first was I made a threshold decision that politically this would not be feasible as a wholly public program, that is, it had to have some private insurance industry participation. After numerous, dozens of meetings with insurance industry representatives, I became convinced that a substantial exclusion required which would create a new market for them, combined with other tax changes included in my bill, would be sufficient to encourage them to come in.

There was a lot of sentiment in the industry for them during the drafting process. Once, however, the bill was introduced, what I call the lowest common denominator, now the industry has shifted, it is against any bill. I made it clear that I think it is an ostrich-like position they are now in, that they are going to end up with something far less to their liking, rather than working constructively on this approach.

The third was cost. There is a tremendous aversion—I need not remind the elected officials here—to being for a tax. This bill has got taxes in it. The days are over when we can responsibly add substantial benefits without including a means to pay for them.

So to the extent that this keeps costs down and reduces the amount of tax revenue that has to be raised, it enhances its political feasibility, although it is still very difficult.

Chairman STARK. In other words, if cutting the waiting period from 2 years to 1 year costs us $10 billion, does making that first year 50 percent get us to $1 billion?

We say the first year we pay 50 percent and then go up. Could we do that for $5 million?

Senator MITCHELL. That is one alternative, a suggested change that I and others are considering, to have some sort of sliding scale so you pay something at the outset.

Chairman STARK. If you could not afford the coinsurance, then you would put that burden on Medicaid.

Senator MITCHELL. That has to be part of this.

The fact is there are always going to be people who cannot afford to pay anything. For an indigent person who becomes eligible to enter a nursing home, my bill does nothing. They are already eligible under Medicaid. We obviously have to continue to make that available to those persons.

This cannot possibly, ought not to and was not intended by me to be an alternative to that. It is a supplement. What it is intended to deal with is the problem of the literally millions of Americans who encounter this and suddenly find a lifetime of savings disappear in what for them is an instant in their lives, under very, very difficult circumstances.

Chairman **Stark**. Mr. Gradison.

Mr. **Gradison**. Thank you, Mr. Chairman.

I want to thank our colleagues from the Senate for their testimony.

There are downsides to serving on the Finance Committee and the Ways and Means Committee, but one thing that it does is focus the mind on how to pay for these things. I congratulate you both for recognizing that we are not going to resolve this problem with a wish list of all the things we want to do and then somebody else can find a way to pay for them. It doesn't work out that way in the end.

I don't have any questions.

I do want to particularly congratulate Senator Mitchell for the attempt he has made in this legislation to create an environment in which the private sector can flourish just as we created the market for medigap, by the way, in which Medicare was written, before our time here. I think there is a valuable lesson to learn from that.

Chairman **Stark**. Mr. Donnelly.

Mr. **Donnelly**. About your recommended changes in the estate tax, you would put a 5 percent surcharge on estates that are now paying tax?

Senator **Mitchell**. Yes.

Mr. **Donnelly**. Which is under 6 percent?

Senator **Mitchell**. It is $200,000. There would be no tax on estates over $200,000.

Mr. **Donnelly**. Part of the long-term care is providing access and additional coverage to the beneficiaries, but another part of it is that we are providing asset protection so people don't become impoverished to become eligible under Medicaid. It seems to me it is a good approach.

How much does it raise?

Senator **Mitchell**. About $3 to $4 billion.

Mr. **Donnelly**. I think that is a good way to approach part of the funding mechanism. It is fair and it is equitable, it seems to me.

Senator **Mitchell**. That is right. It is our expectation that many persons would not have estates, without a change in law, so what we are saying to the group in aggregate is you will now be able to preserve an estate by virtue of the benefits of this program.

So it seems reasonable that they would be willing to pay a 5 percent tax.

Mr. **Donnelly**. My mother happens to be in a nursing home. She is spending down limited savings that my mom and dad had, but they will spend down every penny before they are eligible for Medicaid. It would be much to the advantage of the beneficiary and to the heirs to that estate to pay a 5 percent surcharge. I think it is good public policy and good tax policy.

Senator MITCHELL. Conversely, there is a valid public policy out in the country which we all should understand. You ought to get Bob Ball in here to testify and he will argue, as he has before me, that it is a low priority public policy to protect the estates because the beneficiaries are not the elderly but, of course, the children.

It is an argument with intellectual validity, one I rejected after considering it, but it has to be considered.

Mr. DONNELLY. The fact is, due to societal changes or economic pressures, the children's ability or responsibility to help financially at a point in time when their parents need long-term care, are contributing somewhat because they are the heirs of the estate, because the estate will be reduced by a percentage. I think that is good public policy.

Mr. PICKLE. We are pleased to have your testimony.

Senator Mitchell, I have your memorandum in May about how you would raise the money and about the costs. I am not clear about the costs.

What do you estimate your costs would be over a 1, 2, or 3 year basis?

Senator MITCHELL. I think the current figure, when fully implemented, would be about $18 billion a year.

I will give you a full statement.

[The following was subsequently received:]

14-Jul-88
03:50 PM

DRAFT

Estimate: 339 - S 2305
Preliminary Estimate

DRAFT

Summary Table - All Estimates In Millions of Dollars

Section	1989	1990	1991	1992	1993	Total
Title I - LTC Benefits						
HOME HEALTH SERVICES						
Benefit Outlays	0	0	8,250	12,000	15,400	35,650
Admin Costs	0	50	260	450	520	1,280
NURSING HOME SERVICES						
Benefit Outlays	0	0	15,100	16,350	17,900	49,350
Admin Costs	0	120	510	560	620	1,810
RESPITE CARE SERVICES						
Benefit Outlays	0	0	890	1,020	1,210	3,120
Admin Costs	0	20	30	50	45	145
Title II - Medicaid Provisions						
Offsets from Title I	0	0	(8,800)	(9,940)	(10,030)	(28,770)
Spousal Impoverishment	0	0	0	0	0	0
LTC Buy In	0	0	840	950	1,140	2,930
	0	0	(7,960)	(8,990)	(8,890)	(25,840)
Title III - Financing	Joint Tax Committee Will Provide these Estimates					
Total Outlays	0	190	17,080	21,440	26,805	65,515

Footnotes

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1. All estimates in this table are preliminary and subject to change.
2. Reimbursement levels at Medicaid levels have been assumed. Medicare levels will be used begining in January 1989 for all LTC bills which do not specify levels of reimbursement.
3. Preliminary adjustments have been made for the Catastrophic Protection Act of 1988. Further adjustments will be made in the estimate when the bill is amended to reflect the passage of the bill

Mr. PICKLE. If it is $18 billion, you will save from premium and estate gift taxes.

Will that raise enough money to cover the $18 billion?

Senator MITCHELL. No. When we introduced the legislation, we did not have the home care estimate. That has since come in substantially higher than we anticipated it would be.

Mr. PICKLE. I see.

Senator Durenberger, can you tell me what the cost of your bill would be and how you would raise the revenue?

Senator DURENBERGER. No, Mr. Chairman. My bill will not be finished until sometime this fall, probably September.

What I did in my testimony today is outline the principles I have incorporated. There are not any cost or spending estimates.

Chairman STARK. Mr. Levin.

Mr. LEVIN. We welcome this opportunity to chat with both of you.

I have a couple of questions on home health benefits, because we began to discuss this as the Pepper bill approached the floor. I think we all feel in this area specifics really do matter. So let me ask you a couple of questions.

The home health benefit would be available regardless of income, right?

Senator DURENBERGER. That is correct.

Mr. LEVIN. As it was managed—and it was mentioned in your outline—if the person were qualified because of daily living activities of certain incapacities, it would be available even if members of the family had until the point of application been providing care and were available in the area; is that correct?

Senator DURENBERGER. That is correct.

Mr. LEVIN. This is a somewhat controversial point. We checked into it as we were considering the Pepper bill and looked at the Medicaid experience, which seemed to vary from State to State.

Could there be payment to members of the family? How do we handle that issue? I think it is an important one.

Senator DURENBERGER. I will have to provide you with a written statement on that, Representative Levin. We have a deductible copayment and a maximum cap.

Let me provide you with a written statement on that precise budget, because I don't have the answer to that.

[The following was subsequently received:]

RESPONSE OF SENATOR DURENBERGER

Under my bill, family members who are qualified caregivers providing services in accordance with an approved plan of care would be eligible to receive payment for covered services.

Mr. LEVIN. I think one reason the home health benefit provision may have come in higher than expected is because there are lots of questions that need to be answered here. I think it is well that we ask the questions and try to answer them before we enact the legislation, rather than afterwards.

In a way, you have anticipated this in the nursing home instance by a very rigorous period, a 2-year period, which would eliminate much of the costs to the Government. The average length of stay in a nursing home is under a year. So this is catastrophic nursing home legislation.

With home health benefits, home health care for many, many people would be preferable to a nursing home. There is not the same kind of insulated period. It is difficult for us to know what to do with it.

I was struck when we looked at care coverage for a member of our family. I was struck at the inadequacy of all the policies. It is well enough for us to say let the private sector participate. I think we need to face up to the expense of this kind of coverage and how we are going to handle it, whether it be through the public sector, the private sector or neither.

In the case of a member of my family, she decided, after looking at all the policies, not to buy any of them because there were so many exclusions and she was after home health protection. It really was not anything like totally comprehensive.

So we applaud you and also Senator Durenberger for making an effort to draft legislation in this area.

Senator MITCHELL. My staff advises me that it is contemplated under my legislation that direct payments would not be made to family members, but that family members would be eligible for a respite care benefit included in the bill.

Mr. LEVIN. We have some experience here in Medicaid. We might look at it. We appreciate your testimony and your pioneering efforts on this difficult but critical problem.

Senator MITCHELL. You raise what I think is a very serious question that I alluded to earlier with my reference to the woodworking influence. As you know, the Brookings Institute has just completed a comprehensive study. John Winner and Alice Rivlin testified on that question. He tends to take a more sanguine view of what the effect of the woodworking would be and indicates that it would not be the problem in terms of dramatically increased demand that many of us, myself and you and others, have felt would be the case.

I strongly urge you to solicit his views on that, as he has conducted a number of studies in that area.

Chairman STARK. I want to thank both of the distinguished Senators for taking the time to enlighten us today. We look forward to working with you on this issue next year. I am sure we will begin early on. Thank you both very much.

Next we will have the chairman of the Aging Committee, Hon. Edward Roybal, and Hon. Ralph Regula.

Without objection, the prepared statements of both gentlemen will appear in the record in their entirety.

I know you have labored in this Congress long and hard in this whole area of long-term care.

First of all, I want to state that our subcommittee appreciates the patience you have had with us as we have tried to put together the comprehensive catastrophic part of the medicare bill. Now it is time to turn our attention to long-term care, which you and your committee have been in the forefront on. We are pleased to have you here.

Why don't we get started and get down to work on a very necessary piece of legislation. You may expand on or summarize your statement, or enlarge it in any way you are comfortable.

Mr. ROYBAL. Thank you.

STATEMENT OF HON. EDWARD R. ROYBAL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA, AND CHAIRMAN, HOUSE SELECT COMMITTEE ON AGING

Mr. ROYBAL. I would like to commend the Health Subcommittee on Ways and Means for honoring its pledge to take up long-term care.

As you well know from the events of the past year, the Committee on Aging has an extremely strong interest in solving the problem of approximately 200 million Americans underinsured for long-term care.

Based on information gathered by the Aging Committee, we have two, not just one, systemwide problems. We cannot address one without the other.

The first problem, as you know, is the over 200 million Americans who are underinsured for long-term care. The second problem is the uninsured.

This Nation continues to be disgraced by failure to provide basic insurance coverage to 37 million uninsured Americans, a number that seems to grow every day. Statistics also tell us that there are 9.7 rural Americans working in agricultural jobs who don't qualify for aid to families with dependent children. These families have an average of three to four children who have not been immunized for childhood diseases, nor have they seen a physician since the day of their birth.

These are statistics that are hard to understand and to accept, but nevertheless they are there. They tell us a story of poverty and disease throughout this Nation.

On the issue of quality care, Congress has recently taken major steps to strengthen quality assurance for both home and nursing care. The primary focus has been on Medicare and Medicaid beneficiaries, with the hope that the quality assurance will spill over onto others. I hope that a long-term-care package would extend quality protection to everyone regardless of how the care is financed.

As for cost sharing, to apply large deductibles or long waiting periods is to deny the protection for lower middle income Americans. These Americans cannot afford either, and they are the primary reason for our concern today. For all practical purposes, the wealthy do not need us, but the poor do.

Finally, we face the issue of financing the $50 billion—a major question. We must remember that long-term care is already financed for millions through informal care provided by families unable to maintain the long-term burden. Impoverishment is frequently the eventual result.

The question is, how much of this long-term package should be private and how much should be public?

I can say that the private sector cannot do it alone. The private sector only approach is unacceptable because it would undoubtedly leave most lower middle income Americans unprotected.

My personal preference is for a public sector approach with strong private sector involvement. I believe it is the best way to hold down costs and ensure quality. My suggestion is that we join forces to develop a consensus long-term care package, either through this committee in cooperation with the bipartisan Commission on Comprehensive Care or through a collection of concerned Representatives and Senators, a consensus-type effort that allows us to put away all the egos and focus on solving the problem.

As such, I believe a consensus approach can conclude as was detailed in my legislation, H.R. 200. I still believe the best approach is a national health insurance approach that includes long-term care. It is the best way to ensure quality for everyone. It is the best way to contain costs. I also believe it is the best way to ensure everyone is covered.

As a nation and a Congress, I don't believe we will succeed until we see that there is no American who is denied access to long-term care. I believe the Nation is waiting and will support legislation by the Congress that will provide long-term care for all who need it.

Americans, I believe, hope that they will never have to use it, but at the same time they want to be sure they are protected if the need ever comes.

I realize, Mr. Chairman, that your committee has a tremendous job to do. But I also realize that the need is great and something must be done almost immediately to protect the millions of people in this country that do not have protection insofar as long-term care is concerned.

I am concerned about the fact that we are the only industrialized nation in the world, outside of South Africa—and I believe we are much more sophisticated than South Africa—we are the only industrialized nation in the world that does not have a basic plan that protects the health of its citizens.

I want to congratulate you and your committee for this hearing and I look forward to participating in the debate when this matter is brought to the House of Representatives.

Chairman STARK. Thank you very much for your patience and your challenge and offer of cooperation.

[The statement of Mr. Roybal follows:]

STATEMENT ON LONG TERM CARE

by
EDWARD R. ROYBAL
CHAIRMAN, HOUSE SELECT COMMITTEE ON AGING

to
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS

August 2, 1988

Mr. Chairman, I am very pleased to see the Health Subcommittee of the Ways and Means Committee honoring its pledge to take up long term care. As you well know from the events of the past year, the Committee on Aging, as represented by Mr. Pepper and myself, have an extremely strong interest in solving the problem of 200 million Americans underinsured for long term care.

Let me begin my remarks by stressing that we have two, not just one, system-wide problems. I strongly believe that we cannot address one without addressing the other. As I just stated, the first problem is the over 200 million Americans who are underinsured for long term care. Only the mixed blessing of Medicaid and a little bit of private insurance keep this number from being even larger.

The second problem is the uninsured. This nation continues to be disgraced by its failure to provide even basic insurance coverage to 37 million uninsured Americans, a number that seems to grow every day. The issue of 37 million uninsured Americans will have to be addressed in other hearings and resolved another day, but I believe you share my conviction that it cannot be resolved too soon.

Let me return to the issue of long term care. As we look toward the deliberations of the 101st Congress and a new Administration, I want to establish some basic principles which should govern the deliberations over a long term care package.

Eligibility is the first and possibly most difficult decision we must face. Here, I believe there can be no other choice than to protect every American, regardless of age, income or illness, through one mechanism or another. If one American still fears the financial consequences of a long term illness, we will have failed.

With respect to benefits, a long term care package must include a broad range of benefits. Home care must be included in order to keep the person with their family as long as is feasible. Nursing home care must be included for those situations where the home is no longer the best place for the person and their family. Other types of care, such as day care and respite care, are needed to help optimize the use of limited resources and the setting for caring for the person.

Care management will be an essential tool in deciding if a person needs long term care and ensuring that the person gets the appropriate care at the appropriate time. One of our challenges is to provide no more care management than is necessary. For those who are fully capable of managing their own affairs, the care management role can and should be very limited.

On the issue of quality of care, Congress has recently taken major steps to strengthen quality assurance for both home and nursing home care. However, the primary focus has been on Medicare and Medicaid beneficiaries with the hope that the benefits of quality assurance will spill over to others. I would hope that a long term care package would extend quality assurance to anyone using long term care services regardless of how the care is financed.

As for "cost-sharing," I believe that to require large deductibles and coinsurance or long waiting periods is to deny protection for lower and lower middle income Americans. These Americans cannot afford either and they are the primary reason for our concern today. For all practical purposes, the wealthy do not need us.

Finally, we face the issue of financing, the $50 billion question. We must remember that long term care is already being financed through billions of Medicaid dollars and through millions of hours of informal and formal care "financed" by families.

Financing long term care will require a contribution by everyone, regardless of age. This contribution must be sensitive to a person's ability to pay. Removing the wage cap on the Medicare payroll tax will be one contribution. The Medicaid long term care dollars will be another. Some contribution, sensitive to income, by the elderly and disabled will be appropriate. "Contributions" by the non-elderly and non-disabled will also be necessary. What contributions and how much will depend on the size and structure of the long term care package.

How much of this long term care package should be "private" and how much should be "public?" All I can say for sure is that the private sector cannot do it alone. In fact, I would oppose a "private sector only" approach since it would undoubtedly leave lower and lower middle income Americans unprotected. Now I am not opposed to a package which is a mix of public and private approaches — as long as it works and it covers everyone adequately. I also have to admit that my personal preference is for a public sector approach with strong private sector involvement. I believe that it is the best way to hold down costs, ensure quality and guarantee access.

How do we get from today's hearing to a solution? My suggestion is that we join forces to develop a consensus long term care package either through the Bipartisan Commission on Comprehensive Care or through a collection of concerned Representatives and Senators. A consensus type effort would allow us to put away all the egos and focus on solving the problem.

In closing, let me again state that there are two problems. Thirty seven million Americans are uninsured. Over 200 million Americans are underinsured for long term care. What is the best way to solve both problems? As detailed in my USHealth legislation (H.R. 200), I still believe that a national health insurance approach, which includes long term care, is the best approach. It is the best way to ensure quality for everyone. It is the best way to contain costs. It is the best way to ensure that everyone is covered.

As a nation and a Congress, we will not succeed unless and until no American fears either limited access to needed health and long term care or the financial consequences of illness.

Chairman **Stark**. I think we all look at this as something we will have to roll up our sleeves over and get to work on, starting right now.

I will withhold questioning until we have a chance for your colleague on the Select Committee on Aging to testify.

Next we will hear the Honorable Ralph Regula, the ranking minority member of the Select Committee on Aging.

Mr. **Regula**. I will yield to my colleague from New Jersey, who is ranking on the full committee. I am ranking on the subcommittee.

Chairman **Stark**. Thank you. We will keep these things in order. Mr. Rinaldo.

Mr. **Rinaldo**. I request permission to have my statement in the record in full.

Chairman **Stark**. Without objection.

STATEMENT OF HON. MATTHEW J. RINALDO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. **Rinaldo**. Mr. Chairman and members of the subcommittee, I appreciate the opportunity to testify this afternoon on the issue of long-term care.

The 100th Congress has dealt extensively with health care questions, particularly as it debated H.R. 2470 and when it considered the rule to H.R. 3436, the Pepper bill, to provide a home care benefit under Medicare. We have yet, however, to grapple with the greatest problem of all: the burden of nursing home costs for elderly Americans.

Nursing home and extended home health care costs run into tens of billions of dollars each year. The bulk of those costs are borne by individuals and families, and they can be devastating. The average cost of nursing home care today is about $22,000 a year. But in more densely populated areas such as my own district in New Jersey, costs are much higher.

Nationally, 1½ million people over the age of 65 are in a nursing home. The chances of needing nursing home care for those over 65 are about 1 in 20; but for those over the age of 85, the chances increase drastically to 1 in 5.

Far too often we learn of families or individuals who have had to spend down to poverty providing this care. These costs alone now constitute nearly one-half of all Medicaid expenditures, and they have strained the Medicaid budgets of the States, which pay for about half the costs of this program.

Clearly we cannot allow the current system to continue without major, substantive, fundamental reform.

With the large increase expected in our senior citizen population at the start of the next century, we are facing a public policy problem of devastating proportions. We should act now, before that crisis is upon us, to establish the kind of system that can provide this care without bankrupting individuals or the Federal Government.

In his press release announcing this hearing, the chairman of the subcommittee said that both public and private initiatives are needed to finance long-term care. The issue is how to strike the appropriate balance between public and private financing. I think he is completely correct in that assessment.

We realize we can no longer expect individuals themselves to shoulder these costs. But we also must realize that the Federal Government cannot do it alone either.

My good friend and colleague and chairman of the Aging Committee just said it—having the right balance between public and private financing.

What is required is a partnership among individuals, the Federal Government and private insurers. Legislation I have introduced, H.R. 3501, the Older Americans Long-Term Care Insurance Act, would establish just such a partnership by putting in place a system of private insurance, reinsured by the Federal Government, that would make available insurance policies to individuals at affordable prices.

My legislation contains several important provisions. It would clarify the tax treatment of long-term-care policy reserves, thus giving the insurance industry the certainty it does not now have in pricing these products; afford long-term-care insurance premiums and benefits the same tax-favored treatment as accident and health insurance; allow IRA and life insurance assets to be rolled over into long-term-care policies; encourage employers to offer long-term care policies as an option in cafeteria-style benefit plans; and establish minimum benefit requirements and consumer protection standards along the guidelines developed by the National Association of Insurance Commissioners. I also want to take this opportunity to commend you, Mr. Chairman. I read your press release as I came in this morning. My bill has exactly what you want in this particular provision.

Finally, it would establish a Federal National Reinsurance Corporation that would reinsure primary underwriters against excessive risk in a new, unfamiliar market, at little or no cost to the Federal Government.

Let's look at these proposals. What would be the impact?

My legislation would foster the rapid expansion of the long-term care insurance industry and make available long-term care policies for as little as $15 a month, according to estimates prepared for me by the Prudential Insurance Co. These policies could be purchased by individuals at age 50 to cover long-term nursing and home health care for up to four years. By comparison, bear in mind that over 50 percent of admissions to nursing homes are for less than 3 months and the average length of stay in a nursing home is 456 days—about 15 months.

Is this a solution to the entire long-term care problem? It is not the entire answer, but I think it is very much a part of what we need.

Just as we have asked too much of individuals and families, we should not expect too little, either. If these kinds of policies are available, I think many individuals and families would take advantage of them. The problem is, the private insurance industry is only now beginning to develop and market these products.

It is true, as some point out, that not everyone will qualify for such policies, either because they cannot afford them or they are too ill to qualify. We should not abandon those individuals. Any national long-term care system ought to provide them assistance. But we can only have an effective, affordable system in place if it draws upon all our national resources—the Federal Government, the private sector, and individuals.

In conclusion, Mr. Chairman, I commend the subcommittee for its efforts. This is clearly an issue that demands a legislative response, and I pledge my willingness to work with you in fashioning a compassionate, affordable program.

Thank you.

Chairman **Stark**. Thank you very much.

Thank you very much for your patience, Ralph.

STATEMENT OF HON. RALPH REGULA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO, AND VICE CHAIRMAN, SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE, SELECT COMMITTEE ON AGING

Mr. **Regula**. I will be very brief. I know there are many other witnesses.

You have a Herculean task to put this together. When people discover there is a price tag, it is not quite as exciting as they may have thought.

In a senior seminar, the essence of the discussion last week was that there was a cost. The great challenge you have is to figure out a workable financing system and a system of limiting access to the needy and the fraud and abuse. Those are components we need to put together in a workable bill. There is no doubt that home health care has many workable areas.

I will ask unanimous consent to make my full statement a matter of record.

Chairman **Stark**. Without objection.

Mr. **Regula**. It would seem to me that one of the things that ought to be done in home health care is some type of home health pilot program to determine what the volume of usage would be, what is available in the community in terms of providers.

You are in sort of an uncharted field there. Many of these providers are now family, relatives or whatever. Once it is a program, of course, it changes the dynamics considerably if it is a reasonable one.

So I think we needed a pilot to determine what kinds of providers are needed, what kinds of costs we are going to get into.

Second, I believe that we need to develop a system of tax incentives to deal with the long-term care problem. I won't belabor that because you are familiar with the many different pieces of legislation that are available in the form of tax incentives, use of IRAs without penalty, the employer deductibility.

I would suggest one thing as a member of the Steel Caucus: Some of our findings indicate that if there could be some clarification as to what is deductible in employer-sponsored, long-term care programs, that this would probably stimulate more employers to participate in this partnership that I envision of some Federal, some individual copayments plus employer-paid plans for the long-term care.

I think Senator Mitchell has a number of good ideas, and I am sure that as you try to develop a workable program, that you are going to evaluate the many suggestions. I offer my full testimony as part of that.

I did sponsor a pilot program legislation and I think that particularly in the home care, that we need to go slowly and develop a workable program.

Thank you for the opportunity to testify.

[The prepared statement follows:]

TESTIMONY OF
THE HONORABLE RALPH REGULA, VICE-CHAIRMAN
SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE
August 2, 1988

Mr. Chairman:

Since the beginning of this decade, changes in the reimbursement policies of Medicare, Medicaid and other third-party payers coupled with the continued growth in medical care costs have brought dramatic change to the health industry. From the early cost control mechanisms to the recent expansion of catastrophic coverage both providers and beneficiaries have been confronted with a constantly changing system. This metamorphosis has had an impact upon cost, access and quality of care.

The issue of cost alone, is a threat to over 37 million Americans, both young and old, who are without any public or private insurance. In many cases these people simply do not receive any care. Over one-third of this group are under the age of eighteen years old. Any final determination of society's overall health care responsibilities must include an answer for this group.

The federal commitment to Medicare and our elderly's health is the beginning in addressing this overall issue of universal access to quality health care. Actions taken regarding coverage for catastrophic illness in the acute care setting alongwith reimbursement for prescription drugs provide significant inroads toward a comprehensive policy for America's elderly. It is here we must begin to structure an overall health policy for America.

Expansion of public programs are an appropriate response when the private sector cannot provide for that particular need. That was the basis of the catastrophic bill. However, in our zeal to provide comprehensive coverage we must not omit the important contributions of the private sector which can oftentimes provide services in a more efficient and qualitative manner. From this premise I offer the following recommendations for an enlarged package of health care services to Medicare beneficiaries with private and public alternatives. A basic nursing home benefit must be offered with strong home health care and private insurance components. Furthermore, attention must be directed toward the responsibilities of employers to their retirees' health concerns.

According to a recent study by the Harvard Medical School, 63% of single people age 66 and older will be impoverished after only 13 weeks in a nursing home. Findings by the House Aging Subcommittee on Health and Long-Term Care indicate that by the year 2000, long term health care costs will consume all of the assets of one in every four elderly Americans. Our current reimbursement system mandates destitution under tightening Medicaid laws and then the forced institutionalization of the individual to receive care. It is difficult, if not impossible, for a person to remain in their home even if the care is less expensive and more appropriate. Any program designed to provide for long-term health care must resolve this inequity and provide for suitable alternatives to institutional care.

Last year, when the Subcommittee on Health & Long-Term Care was considering the need for home health care, I strongly advocated an expansion of Medicare to provide this alternative as part of an overall umbrella of benefits. In providing home care we must ensure that neither quality and access be compromised, nor should costs to the beneficiary be burdensome. I am concerned that a rapid and unthought expansion of the program offers the likelihood of a system plagued by abuse and fraud. Rather than benefiting from the increased benefits the elderly could be victimized through unscrupulous or unfit care.

Most experts agree that the home care industry is not sufficiently developed to cope with the rapid increase in demand for services that would come from such a Medicare expansion. As the industry grows to meet the additional demand shortages will occur in certain areas making it difficult to obtain services. In many cases the care given will be substandard because of poorly trained care givers and inefficient administration.

Apart from these concerns, I believe a plan can be structured to provide covered services that are limited to recognized effective and necessary home care services that can keep people in their homes rather than an institution. A key aspect is the use of managed care organizations which would oversee and control the provisions of services by the home health agency. Case management provides the dual role of assessing the quality and appropriateness of the care. Unfortunately, the design of these systems remain uncertain and should merit the highest attention in any final plan.

Another factor is the determination of eligibility. Qualifying for home care benefits is much different from either the acute or long-term care institutional settings. If based upon the use of the contemporary ADLs (activities of daily living) the program should limit coverage to persons with three or more ADLs. This would cover those persons actually needing health care that can be provided in the home, which would otherwise require their institutionalization, while exempting individuals who are basically fit but could benefit from less intensive nursing and social services. Currently, 8 out of every 10 persons receiving care in the home receive it from an informal and unpaid source, usually the family. To broaden coverage further than two ADLs will open the "floodgates" and reimburse family and friends for care which has been primarily a family commitment since the beginning of our nation.

Incentives must exist which encourage responsible use of the benefits. The use of copayments, deductibles or other cost sharing mechanisms must be used to discourage frivolous use of the benefit. The monetary benefit to the program would be minimal. Some specific suggestions would be a monthly cap on the benefit not to exceed 75% of the local skilled nursing care average cost. An annual deductible similar to Medicare Part A could be implemented to adjust with yearly inflation. The use of a copayment of twenty to twenty-five percent would further encourage thoughtful participation without hamstringing the program's effectiveness

Finally, the most important and most difficult goal to achieve in any proposal is the assurance of certain levels of quality in care given to patients in the home. As discussed, the case management element functions as one level of review. But its mission is dualistic, also being to direct the individual to the most appropriate care. The pressures of reimbursement and limited resources of the overseeing agency can operate to decrease attention to quality. It is necessary to compliment this review of individual cases with an institutional level examination by PROs or similar organization.

Implementation of this portion of the package requires careful consideration. I have heard the testimony of countless witnesses recounting the horrors of early hospital dismissals under Medicare's most recent program reforms, the DRG. The same type of unexpected problems will be encountered if we don't attempt to answer the questions before beginning to provide for home care coverage. Congress must not establish a program which offers a benefit that cannot be accessed or if obtained is characterized by an uncertainty over the quality of the service. That is neither helping the elderly or spending government dollars responsibly. Instead we should conduct a major trial demonstration. The benefits of such an approach are well documented.

Next, I would like to make two brief comments on the role of private insurance in the payment of nursing home care. First, the selective use of preferential tax treatment to the individual can encourage the development of affordable and effective private long-term care insurance.

According to a 1987 HHS report it was estimated that there is a savings of two Federal Medicaid dollars for each dollar of Federal revenue lost through tax incentives for private long term care financing. Over fifty percent of Medicaid's current dollars pay for long-term care.

I strongly urge allowing individuals to use their IRAs, on a tax-free basis, to purchase approved long-term care insurance for themselves, or their family. These insurance premiums should qualify for the limited medical deduction allowed individuals under section 213. Taxpayers should be permitted to use pension plan proceeds to pay for such insurance without such funds becoming taxable income. Finally, individuals with accumulated equity in insurance or annuity contracts should be allowed to exclude from their income these funds when used to finance long-term care insurance.

Second, employers are a primary element in encouraging the development of private insurance as well as a necessary force in any final government package. As the Vice-Chairman of the Steel Caucus' Executive Committee, I am currently conducting an examination of the health care pensions for employees/retirees of the industry. Our preliminary findings indicate modest tax clarifications could significantly improve employer-sponsored coverage.

Private insurance is less expensive when offered through the workplace or as a retiree benefit due to lower administrative and marketing costs. Furthermore, the employer will typically have more sophisticated market expertise in addition to greater leverage to negotiate a more favorable package.

Congress must provide a definition of "qualified long-term care insurance" for purposes of the Internal Revenue Code. The tax status of these insurance reserves should be treated like non-cancelable accident and health insurance to permit deductions by insurance companies. Of particular importance, is to include employer-paid plans under this definition, particularly those providing qualified plans to retirees. Employer contributions to the plan would be deductible while being excluded from employee's income. Also, we must encourage employers' to prefund these plans. This could be accomplished by precluding employers from obtaining refunds of contributions and interest through the 100% excise tax mechanism in section 4976 while offering favorable tax treatment for qualified pre-funded plans.

These private sector incentives should be immediately effective in any final legislative package.

Finally, I would to discuss the third leg of this proposal which is an expansion of Medicare to provide a basic long-term care benefit. This past April, legislation was introduced by Senator George Mitchell to create a federal program to help pay for the costs of nursing home care. This bill provides several useful ideas for establishment of a comprehensive program.

An exclusionary period requirement before Medicare will pay for such care is an effective deductible to limit the benefit to only the most needy. This will permit the continuance of the private sector market in the form of "gap" policies as well as "cadillac" products extending beyond Medicare coverage. Other cost sharing requirements should also be instituted similar to those items I mentioned earlier concerning home health care.

Eligibility should be based solely upon Medicare Part A criteria, making it a basic benefit available to all beneficiaries. Coverage should extend to all care provided in skilled nursing or intermediate care facilities. A monthly cap on reimbursement based on geographical averages would also help control costs and leave another portion of the market open to the private sector. Again, the use of a trial project would permit a more thoughtful structuring of the final program.

In conclusion, the breadth of reform in these three areas of home care, private insurance, and nursing home care depends upon adequate funding. Critics state that long-term care coverage is difficult to establish because of the high costs and use patterns by the elderly. Some believe that large infusions of capital will be required to provide comprehensive coverage. Obviously, this is an expensive program and will require new sources of revenue. But, a significant portion of that cost can be met with a more efficient allocation of existing resources by the public and private reimbursement systems.

Dr. Marc Cohen, a distinguished scholar of the Health Policy Center of Brandeis University, recently stated that the expected annual cost per person over age 65 for nursing home care is between $532 and $760. These costs are distributed very unequally. Only 13% of the elderly account for 90% of all nursing home expenditures. These statistics indicate the possibility and desirability of risk-sharing arrangements among the elderly such as premium sharing.

However, the majority of the costs will require new revenue. Sources include: removal of $45,000 cap on annual income subject to the Medicare payroll tax, surtaxes on gift and inheritance transactions, "sin" taxes, and hospital/employer taxes. All of these have received close consideration. What remains to be done is the matching of highest priority benefits to available cash resources.

I anticipate introducing legislation incorporating these recommendations.

Thank you for the opportunity to discuss this important issue before the subcommittee.

Chairman STARK. I want to thank all three of you. I think as the testimony unfolds today, you will see along with us that this problem is broad. It will, of necessity, have to be a partnership between private and public. That is the easy part. When we get down to the parts of who pays what and in the climate of deficit reduction, we will get into a host of problems.

I think it is important to remember that we do have a Medicaid program for better or for worse, and whatever indignities some people may suffer in qualifying, it is a long-term-care program.

We can make it better. Although it does not fall under this committee's jurisdiction, I don't think we can discuss long-term care unless we remember that we also have this program in place and for many Americans it is, in effect, the safety net of last resort.

I hope that all of you gentlemen, your committee particularly that has gathered so much testimony across the country, will help us. We are going to make a start and hopefully hit the ground running in 1989, and I would request that you all work with us to see if we can't get this out.

Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman.

I, too, would like to thank all three of the witnesses for their appearance here and for the excellent work which has been going on in your committee on this subject.

I was struck by the continuing reference to the need for emerging public and private efforts not only in the testimony from this panel but some whom you might have heard if you came earlier.

The figure which Chairman Roybal used of $50 billion, used to be a ballpark estimate generally accepted as to what a comprehensive long-term-care program would cost. Of course, there is discussion as well about the very major problem of the health uninsured which could be another $50 million, $1,500 apiece, which is maybe on the low side for each of those 30-odd million people.

We don't have $100 billion in a back pocket right now nor do we have a chance in the world of levying taxes. So we are going to have to think through how to involve the private sector and what exclusions or tests or however you want to call it would be imposed in order to take what resources are available and get them to the people who need it most. That is not an easy process.

We welcome your assistance, and thank you for being here.

Chairman STARK. Mr. Anthony.

Mr. ANTHONY. Thank you, Mr. Chairman.

I would like to address this inquiry to Matt and to Ralph. In both your proposals, you have an extensive list of what would be considered tax expenditures, tax incentives as a way to accomplish part of your goal.

Have you made a formal request to the revenue-estimating bodies of Joint Tax and Treasury to see what those costs would amount to?

Mr. REGULA. I don't have any.

Mr. RINALDO. I don't have any either. I understand that some of these are already in effect, so to speak, but not codified. In other words, they are being treated that way—some, not all of them.

Mr. ANTHONY. Some of the items that are mentioned, Senator Mitchell testified that he had already requested revenue estimates on, but Ralph has come up with some ideas on maybe taking IRAs and allowing those funds to be used for a purchase. You had about four in a row there.

Mr. Chairman, I think it would be a good idea if we could make a formal request to get some of these costed out, because we have at the moment Senator Pepper's bill, which is the big one on raising the capital of the income, and then obviously the sin taxes are always floating around for everybody's consideration.

But these two gentlemen have come up with kind of a different shopping list, if you will, and I think it would be interesting to get them all costed out.

Mr. **Rinaldo**. You raise a good point. As I understand right now, the Treasury Department is not challenged by insurance companies and they are treating long-term-care policy reserves the same way they are treating life insurance reserves.

Chairman **Stark**. If the gentleman would yield, I am suspicious that the Department of the Treasury hasn't ruled yet and that is what is holding up the estimate.

I think what you are suggesting is what the insurance companies would like, but Treasury has been silent and therefore we are unable to get an estimate until Treasury decides what their rule is. We are kind of one shoe off and one shoe on in getting these estimates. The ball is in Treasury's court.

Mr. **Rinaldo**. That is correct, but it is also my understanding that they are treating the reserves in the manner in which we would like to see them treated in the legislation and the only thing that would cost additional funds would be allowing the IRA life insurance assets to be rolled over into long-term-care policies.

Mr. **Anthony**. The reason I think it is important, and I didn't get a chance to inquire of Senator Pepper, he made a statement about the chairman having promised to reserve revenue from a particular force.

I am not sure that I would give full faith and credence to any kind of a commitment on a reservation, because, one, you have a big committee here and there are going to be a lot of other ideas that are going to come forward in terms of using other sources of revenue for a particular type of extension of benefits.

I think if we can get all the ideas costed out, we wouldn't necessarily have to rely upon one particular source of revenue and I would hate to get into a squabble next year if we are marking this bill up over somebody who thinks that they have a commitment from the chairman of the committee to reserve a particular way.

I haven't made up my mind how I want to pay for this. I want to get more input and we have to have the revenue estimation.

Senator Mitchell has already told us something that this committee is aware of: If they give you a faulty or a contradictory revenue estimate, we are still forced to deal with it in terms of markup.

So I would love to get way ahead of the game so if there are those arguments, I think this is where you could lend your weight of authority as the chairman of the subcommittee and ask for revenue estimates for these various pieces of legislation.

I think if we could get those before the end of the year, we would have a better opportunity for the staff to put them all together so we could take a good look at them.

Chairman STARK. I thank the gentleman for the discussion.

Mr. Moody.

Mr. MOODY. No questions.

Mr. ANTHONY. Mr. Chairman, one final question.

You also state that you are doing some study on examining insurance and pensions as the vice-chairman of your Steel Caucus.

Mr. REGULA. Yes, the deductibility question on if a company were to offer long-term care as a benefit to the employee, it is not clear as to whether that is a deductible item to the employer at this point, so companies are reticent to embark on that kind of program.

The insurance industry has been quite interested in developing coverage for long-term care at a reasonable cost, but it obviously would have to start early in the employee's service so that you could build up reserves.

I think the industry needs to have clarification as to whether or not this is a deductible item to them and not a taxable benefit to the employee, because you flirt, whenever you need revenues, with the idea of making some benefits taxable and that puts somewhat of a chill on it.

Mr. ANTHONY. The Oversight Subcommittee has already held a hearing on the broad area of pensions and we are going to be doing more tangentially.

Anything you could come up with could help us and maybe the two working together could find a solution for the long-term health.

Mr. ROYBAL. One point: Senator Pepper called me and told me that he had been visited by the chairman of the full committee and that a commitment had been made with regard to a funding mechanism.

On the other hand, in discussing it with the Senator, while he feels that this commitment should definitely be reviewed by the full committee, he doesn't limit funding just through that medium. That is just something that can definitely be used as a part of an overall funding mechanism, and I am sure that the chairman of the full committee will definitely honor his commitment and use it as such.

Chairman STARK. It is going to take a lot of creative thinking to figure out the various sources. Not that they are not there, it is putting together that delicate political coalition of young and old, employed and unemployed.

We can work together to get something passed on the floor, and so I think that exploring all of these options is going to make it easier for us to put together a package.

Mr. ROYBAL. Mr. Chairman, I have faith in the ability of this committee, in your background and experience, and I look forward to the time when you bring a bill to the House of Representatives.

Chairman STARK. Thank you, gentlemen.

I am going to ask the remaining witnesses if they would mind coming to the witness table. The Hon. Mike Bilirakis, Joe Kleczka, John Rowland, French Slaughter, and Peter DeFazio.

Congressman Hunter is not with us, but I ask unanimous consent that his statement be made part of the record.

I also ask unanimous consent that the prepared statements of the gentlemen at the witness stand, and Congresswoman Lloyd, also be made a part of the record, and ask you gentlemen if you would proceed in the order in which you appear on our witness list, and we will hold our inquiries until the completion of your testimony. You could summarize it or expand on your prepared testimony in any manner you are comfortable with.

Mike.

STATEMENT OF HON. MICHAEL BILIRAKIS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. BILIRAKIS. Thank you, Mr. Chairman. I will paraphrase in the interest of time.

I thank you, Mr. Chairman and members of the committee, for holding this hearing and for offering us the opportunity to be heard. I served with you and many others of this committee on the conference committee for catastrophic, and I have no hesitation in saying I am not sure that there are any other committees in the Congress that work as hard as you do and care more about this subject and know more about it. I commend you for that.

As I mentioned during the catastrophic conference meetings, Mr. Chairman. I held a series of town meetings in my district last fall. Practically 50 percent of my district consists of seniors or those about to be seniors, and whereas those people were not really all that much concerned with the catastrophic protection legislation, they were greatly concerned about the need for long-term care. I commend again this committee for its work towards that end.

I also serve as Chairman of the Republican Research Committee's Task Force on the Elderly. We held a very lengthy hearing on this issue and have heard a variety of health care experts give us their ideas on how our long-term care problems can be solved.

In an effort to provide some assistance without unduly adding to our budget deficit, I have introduced legislation, H.R. 2039, to provide the private sector with incentives to plan for and take care of its own long-term-care needs. While fully realizing that H.R. 2039 alone is not the answer to our society's long-term care dilemma, I do feel that it contains some good provisions that deserve consideration when we debate long-term care initiatives on the floor.

First, H.R. 2039 contains a provision calling for tax deductions to heads of households who care for elderly family members in the home. Under this provision, all legitimate medical expenses exceeding 5 percent of adjusted gross income will be deductible on IRS returns.

My thinking is that not only will this tax incentive help delay expensive institutionalization, but it will encourage families—the backbone of our great Nation—to stay together as long as they possibly can.

Second, H.R. 2039 contains a provision calling for a tax credit, in the form of an extension of the charitable contribution, to these doctors and nurses who donate time and materials to care for homebound patients.

For medicines and materials, the deduction will be a full 100 percent, while the deduction for time would be 50 percent of the prevailing rate for a doctor or professional nurse's time as determined by medicare.

The amount deductible will be capped at double the charitable contribution and will be subject to the same restrictions as defined in the Internal Revenue Code of 1954.

Accountability will come in the form of a standardized voucher to be filled out by both patient and provider to be processed through HHS.

If enacted, this provision will not only help avoid expensive hospital and doctor charges, but could conceivably bring back the long-departed housecall.

Furthermore H.R. 2039 will allow withdrawals from IRAs for the purpose of long-term health care—meaning the amounts paid for custodial care in or out of nursing homes or the insurance premiums for long-term care would be tax exempt.

Finally, H.R. 2039 would amend the Internal Revenue Code to make employer funding for health benefits for future retired benefits exempt.

All in all, Mr. Chairman, I see H.R. 2039 as helping people to help themselves by giving them incentives, mostly in the form of tax credits, to encourage them to plan for and meet long-term-care needs.

While fully realizing that H.R. 2039 alone is not the answer, I also know that, however great the need, we cannot continue to completely rely on the Federal Government.

For this reason, I have introduced H.R. 2039 and intend for it, in combination with other legislative initiatives, to provide our senior citizens with their peace of mind which they need and so greatly deserve in the golden years.

Our elderly have built and molded this great country of ours. They are our parents and grandparents; they are the veterans of our world wars, the teachers who taught us to read and write, the farmers and factory workers of yesterday who toiled long hours for a couple dollars a day, et cetera.

They have contributed much to our society and they deserve for us to not forget them where their need is greatest.

Again, Mr. Chairman, I commend you for holding today's hearing and encourage you to continue your initiative on this most important issue so that the necessary work in this area will quickly be done and our senior citizens can sleep calmly at night.

Thank you very much, sir.

Chairman STARK. Thank you very much, Mike.

[The statement of Mr. Bilirakis follows:]

STATEMENT OF CONGR. MICHAEL BILIRAKIS (R-FL)
W&M; HEALTH SUBCOMMITTEE
LONG TERM CARE
AUGUST 2, 1988

MR. CHAIRMAN, DISTINGUISHED MEMBERS OF THE SUBCOMMITTEE THANK YOU FOR THE OPPORTUNITY TO BE HEARD THIS AFTERNOON. I APPRECIATE THIS OPPORTUNITY AND I APPRECIATE THE FORESIGHT THAT YOU HAVE DEMONSTRATED BY HOLDING THIS HEARING ON WHAT IS ONE OF THE MOST IMPORTANT ISSUES OF OUR DAY--HOW TO PROVIDE OUR SENIOR CITIZENS WITH PROTECTION AGAINST THE BANKRUPTING COSTS OF LONG TERM CARE WITHOUT UNDULY ADDING TO OUR VERY DELICATE BUDGET SITUATION.

MR. CHAIRMAN, AS YOU MAY KNOW, I REPRESENT ONE OF THE MOST ELDERLY DISTRICTS IN OUR NATION. I TRY TO KEEP IN CLOSE TOUCH WITH MY CONSTITUENTS AND MAKE AN EFFORT TO LEARN OF THEIR NEEDS AND DESIRES IN ORDER TO BETTER REPRESENT THEM. LAST FALL, I HELD A SERIES OF TEN TOWN MEETINGS IN MY DISTRICT AT WHICH THE HEALTH CARE ISSUE WAS DISCUSSED BY WAY OF THE CATASTROPHIC LEGISALTION THEN PENDING IN CONGRESS.

WHILE MY CONSTITUENTS HAD MIXED FEELINGS ABOUT THE MEDICARE CATASTROPHIC PROTECTION ACT, THERE WAS ALMOST UNANIMOUS CONSENT IN THEIR CONVICTION AND DESIRE FOR FEDERAL ASSISTANCE VIS A VIS LONG TERM CARE EXPENSES.

I HEARD, AND CONTINUE TO HEAR, COUNTLESS HORROR STORIES FROM SENIOR CITIZENS WHO HAVE EXPERIENCED THE DEVASTATION OF NOT ONLY SEEING A LOVED ONE INSTITUTIONALIZED BUT WHO HAVE HAD TO DEAL WITH THE LOSS OF THEIR LIFE'S SAVINGS AND EVENTUAL BANKRUPTCY IN ORDER TO PAY FOR THE CARE OF A LOVED ONE.

IT IS NO WONDER! WITH THE COSTS OF A NURSING HOME AVERAGING $30,000 PER YEAR, IT IS EASY TO UNDERSTAND HOW SAVINGS, EARNED THROUGH HARD WORK AND THRIFT DURING DEPRESSIONS, RECESSIONS, AND WORLD WARS, QUICKLY DISSIPATE.

I AM FULLY CONSCIOUS OF THE GREAT NEED THAT EXISTS FOR FISCAL RESPONSIBILITY IN GOVERNMENTAL SPENDING, BUT, AT THE SAME TIME, MR. CHAIRMAN, I ALSO STRONGLY FEEL THAT THE SECURITY OF OUR SENIOR CITIZENS IS AN OBLIGATION OF OURS. I THINK THAT THE TIME TO PROVIDE THEM WITH SOME PEACE OF MIND REGARDING LONG TERM CARE EXPENSES IS LONG OVERDUE.

AS CHAIRMAN OF THE REPUBLICAN RESEARCH COMMITTEE'S TASK FORCE ON THE ELDERLY, I HAVE LONG WORKED ON THIS ISSUE AND HAVE HELD HEARINGS AT WHICH WE HEARD A VARIETY OF HEALTH CARE EXPERTS GIVE US THEIR IDEAS ON HOW OUR LONG TERM CARE PROBLEMS CAN BE SOLVED.

IN AN EFFORT TO PROVIDE SOME ASSISTANCE WITHOUT UNDULY ADDING TO OUR BUDGET DEFICIT, I HAVE INTRODUCED LEGISLATION, H.R. 2039, TO PROVIDE THE PRIVATE SECTOR WITH INCENTIVES TO PLAN FOR AND TAKE CARE OF ITS OWN LONG TERM CARE NEEDS. WHILE FULLY REALIZING THAT H.R. 2039 ALONE IS NOT THE ANSWER TO OUR SOCIETY'S LONG TERM CARE DILEMMA, I DO FEEL THAT IT CONTAINS SOME GOOD PROVISIONS THAT DESERVE CONSIDERATION WHEN WE DEBATE LONG TERM CARE INITIATIVES ON THE FLOOR.

FIRST, H.R. 2039 CONTAINS A PROVISION CALLING FOR TAX DEDUCTIONS TO HEADS OF HOUSEHOLDS WHO CARE FOR ELDERLY FAMILY MEMBERS IN THE HOME. UNDER THIS PROVISION, ALL LEGITIMATE MEDICAL EXPENSES EXCEEDING 5% OF ADJUSTED GROSS INCOME WILL BE DEDUCTIBLE ON IRS RETURNS. MY THINKING IS THAT NOT ONLY WILL THIS TAX INCENTIVE HELP DELAY EXPENSIVE INSTITUTIONALIZATION, BUT IT WILL ENCOURAGE FAMILIES (THE BACKBONE OF OUR GREAT NATION) TO STAY TOGETHER AS LONG AS THEY POSSIBLY CAN.

SECONDLY, H.R. 2039 CONTAINS A PROVISION CALLING FOR A TAX CREDIT, IN THE FORM OF AN EXTENSION OF THE CHARITABLE CONTRIBUTION, TO THOSE DOCTORS AND NURSES WHO DONATE TIME AND MATERIALS TO CARE FOR HOMEBOUND PATIENTS.

FOR MEDICINES AND MATERIALS, THE DEDUCTION WILL BE A FULL 100%, WHILE THE DEDUCTION FOR TIME WOULD BE 50% OF THE PREVAILING RATE FOR A DOCTOR OR PROFESSIONAL NURSE'S TIME AS DETERMINED BY MEDICARE. THE AMOUNT DEDUCTIBLE WILL BE CAPPED AT DOUBLE THE CHARITABLE CONTRIBUTION AND WILL BE SUBJECT TO THE SAME RESTRICTIONS AS DEFINED IN THE INTERNAL REVENUE CODE OF 1954. ACCOUNTABILITY WILL COME IN THE FORM OF A STANDARDIZED VOUCHER TO BE FILLED OUT BY BOTH PATIENT AND PROVIDER TO BE PROCESSED THROUGH HHS.

IF ENACTED, THIS PROVISION WILL NOT ONLY HELP AVOID EXPENSIVE HOSPITAL AND DOCTOR CHARGES, BUT COULD CONCEIVABLY BRING BACK THE LONG-DEPARTED HOUSECALL.

E PURPOSE OF LONG TERM HEALTH CARE--MEANING THE AMOUNTS PAID OR CUSTODIAL CARE IN OR OUT OF NURSING HOMES OR THE INSURANCE PREMIUMS FOR LONG TERM CARE WOULD BE TAX EXEMPT.

FINALLY, H.R. 2039 WOULD AMEND THE INTERNAL REVENUE CODE TO MAKE EMPLOYER FUNDING FOR HEALTH BENEFITS FOR FUTURE RETIRED BENEFITS TAX EXEMPT.

ALL IN ALL, MR. CHAIRMAN, I SEE H.R. 2039 AS HELPING PEOPLE TO HELP THEMSELVES BY GIVING THEM INCENTIVES, MOSTLY IN THE FORM OF TAX CREDITS, TO ENCOURAGE THEM TO PLAN FOR AND MEET LONG TERM CARE NEEDS.

WHILE FULLY REALIZING THAT H.R. 2039 ALONE IS NOT THE ANSWER, I ALSO KNOW THAT, HOWEVER GREAT THE NEED, WE CANNOT CONTINUE TO COMPLETELY RELY ON THE FEDERAL GOVERNMENT.

FOR THIS REASON, I HAVE INTRODUCED H.R. 2039 AND INTEND FOR IT, IN COMBINATION WITH OTHER LEGISLATIVE INITIATIVES, TO PROVIDE OUR SENIOR CITIZENS WITH THE PEACE OF MIND WHICH THEY NEED AND SO GREATLY DESERVE IN THEIR GOLDEN YEARS.

OUR ELDERLY HAVE BUILT AND MOLDED THIS GREAT COUNTRY OF OURS. THEY ARE OUR PARENTS AND GRANDPARENTS, THEY ARE THE VETERANS OF OUR WORLD WARS, THE TEACHERS WHO TAUGHT US TO READ AND WRITE, THE FARMERS AND FACTORY WORKERS OF YESTERDAY WHO TOILED LONG HOURS FOR A COUPLE DOLLARS A DAY, ETC. THEY HAVE CONTRIBUTED MUCH TO OUR SOCIETY AND THEY DESERVE FOR US TO NOT FORGET THEM WHERE THEIR NEED IS GREATEST!

AGAIN, MR. CHAIRMAN, I COMMEND YOU FOR HOLDING TODAY'S HEARING AND ENCOURAGE YOU TO CONTINUE YOUR INITIATIVE ON THIS MOST IMPORTANT ISSUE SO THAT THE NECESSARY WORK IN THIS AREA WILL QUICKLY BE DONE AND OUR SENIOR CITIZENS CAN SLEEP CALMLY AT NIGHT!

THANK YOU, MR. CHAIRMAN.

Chairman STARK. Gerry Kleczka.

STATEMENT OF HON. GERALD D. KLECZKA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WISCONSIN

Mr. KLECZKA. Thank you, Mr. Chairman.

When I initially sought a seat on this committee, I was not referring to a witness seat. However, I think for the time being it will suffice.

I am pleased to participate in these hearings because H.R. 5085 and the Long-Term Health Assistance Act, of which I am an original cosponsor with Dave Obey, are complementary bills. In fact, they are a perfect fit.

It is becoming increasingly clear that the need for fully coordinated public and private long-term health care programs is no longer in question. Information readily available to the Congress warns us of health care chaos unless decisions are made now concerning the direction long-term care is to take in the United States.

Let's put this information to use. As lawmakers, what are we facing?

Census Bureau statistics show that the elderly population will continue growing rapidly through the remainder of the 20th century into the next. A scant 42 years from now, in the year 2030, 21 percent of our population will be over the age of 65. This trend couldn't be clearer if it were broadcast news, for we see the evidence every day in stores and on the streets. Already 15 million more Americans are living to be 75 years and older than were doing so in 1980. The age 85 and older group is expanding the quickest. And this oldest elderly group requires more labor and capital intensive health care than any other elderly population group. However, the very medical advances which help us live longer impoverish all but the wealthiest.

Claiming that the elderly are richer today because of their entitlement program benefits—as some individuals do—is simply misleading. I would point out that health care is much more complex and expensive than ever before, and the elderly are not employed and drawing pay checks to foot their bills. In fact, they depend upon assistance from limited family resources, their Social Security income, and the strained Medicare and Medicaid programs.

Medicaid alone spent one third of its budget—$14.7 million—for nursing home care in 1985. And as you know, Medicare will begin covering acute care under its catastrophic protection program in 1989, but cannot at this time expand to include long-term care coverage for beneficiaries. Furthermore, less than 1 percent of the elderly on Medicare have a long-term care policy. Therefore, vital but expensive health care forces the elderly, in many cases, to liquidate their one truly valuable asset, the family home, in order to cover the medical expenses of either a spouse or themselves.

It is shameful that Americans have to sell off their assets in order to pay for their medical bills. But until the Federal budget deficit is significantly reduced, Government is limited in what it can do to relieve the financial burden of health care to the elderly.

This means the private sector's role must expand. Existing factors indicate that providing long-term care is a responsibility which must be shared by the private insurance market, the Government, and the effected citizens, themselves.

I believe debate over the Government's role will continue in the 101st Congress when, I trust, the House and Senate will transmit a comprehensive medicare long-term home care and nursing home care act to the next President.

Legislation currently in both Chambers—specifically the Obey and Mitchell bills—tackle the thorny problems of financing long-term care in the most cost-effective way possible, by requiring some copayments and deductibles for covered services. These bills cover the three major long-term care services used by the elderly: home health care, respite care, and nursing home care. These companion bills ensure that individuals capable of shouldering some of the costs of their long-term care do so, thus allocating benefits and costs fairly among all beneficiaries.

Furthermore, the Obey and Mitchell bills are self-financing. These bills do not add to the national budget deficit. The long-term care program proposed by these bills is therefore self-sustaining, requiring no supplemental injections from the taxpayers. And like the recently enacted Catastrophic Protection Act, these bills would not force a community spouse into impoverishment in order to pay an institutionalized spouse's long-term care bills. This measure is particularly useful for older women, one of our Nation's overlooked poverty groups.

The Obey and Mitchell bills almost certainly will be the basis of long-term care legislation enacted next year. But as you know, many seniors and disabled americans have expressed dismay over the House's rejection of an earlier proposal, the Pepper long-term care plan.

Chairman Pepper's proposal was laudatory in its goals, but for many reasons the Pepper plan would have proven unworkable. First, the Congressional Budget Office (CBO) found that the plan's cost projections were significantly underestimated. The Pepper plan would have bankrupted itself soon after taking effect, forcing Congress to raise taxes, reduce benefits, or require beneficiaries to begin copaying in order to save it.

Second, the Pepper plan was narrow, covering only home health care services. For those individuals requiring continuous acute care or else temporary care, home health services are insufficient and unresponsive.

Finally, the Pepper plan did not ensure that the cost of providing its benefits was allocated fairly among eligible individuals who are able to pay for them.

The House rejected the Pepper plan rule. Now we are entering long-term care discussions centering around broader, self-financing concepts, using a cohesive public-private approach.

Chairman Pepper is the elderly's No. 1 voice in Congress. And through his steadfast and unflagging advocacy of their concerns, the elderly aren't ignored here. They, and we, owe Chairman Pepper much. Thank you.

The public-private partnership underlying the Obey and Mitchell bills is workable. However, the 2-year waiting period before nursing home benefits kick in included in the Obey/Mitchell bills is proving an almost intractable dilemma. It is during this period that most beneficiaries spend down their assets in order to pay medical bills.

Instead of impoverishment, how about sound long-term care insurance? The private market is much more flexible and competitive than the Federal budget, and therefore capable of adequately matching the demand for long-term care coverage with an actual supply—a policy.

As all of us gathered here know, pooling resources and sharing costs, the basic principle of all insurance, protects us against auto, home and other types of liability at a profit to the issuer. And though it is true the elderly face drastically high expenses, it is not therefore also true that comprehensive private health insurance for this population group would prove unprofitable to the issuer.

Frankly, if the industry offered a policy seniors wanted to purchase, they would do so. I can only predict that the sales of a truly comprehensive policy would cover most high risks and still generate healthy reserves. H.R. 5085 establishes such standards, and provides penalties for noncompliance.

It makes sense to regulate the fledgling long-term care industry now, before fraudulent advertising and actuarial practices mature. The standards imposed by H.R. 5085 are reasonable, following the National Association of Insurance Commissioners (NAIC) precedent-setting medigap model. This bill also incorporates measures similar to the recommendations made in the May 1988, Consumer Reports on long-term care policies. H.R. 5085 stands a good chance of passage based on key consumer and insurance support.

Right now only states regulate long-term care insurance. The abuses which led to Congress establishing medigap standards are very similar to some of the reports we hear about the long-term care insurance industry's practices. Let's prevent history from repeating itself. I urge you to support H.R. 5085, a useful and operable proposal for issuers and potential policyholders alike.

Finally, the availability of comprehensive long-term care policies could dramatically reduce the burden of a 2-year waiting period before proposed Medicare nursing home benefits take effect. Let me be clear on one point: Congress is not retreating from its intention of providing long-term health care to the elderly and disabled. However, through consideration of H.R. 5085, we are encouraging private insurance to enter a no losers game:

H.R. 5085 would guarantee not only that the proposed medicare nursing home benefit's 2-year waiting period is less onerous financially, but that the copayments and deductibles for which the beneficiary is personally responsible are also covered, partially or in full, by private insurance. This is a great deal for all parties, no matter how one looks at it.

Because it is sensible and complements existing proposals, I support H.R. 5085, the Long-Term Care Insurance Standards Act of 1988. The prognosis on long-term care is before us, as well as a remedy to what is currently ailing the industry. I urge my colleagues to support speedy treatment of the private long-term care insurance industry and vote in favor of H.R. 5085 when it comes up for consideration before this committee and on the floor.

Thank you very much.

Chairman STARK. Thank you, Gerry, very much.

Our next witness will be the Honorable John Rowland.

STATEMENT OF HON. JOHN G. ROWLAND, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CONNECTICUT

Mr. ROWLAND. Thank you, Mr. Chairman.

I would also like to summarize my prepared remarks.

First I would like to express my thanks to the subcommittee for permitting me to testify today regarding an issue of immense importance to the future of our country: the provision of affordable, quality long-term health care for all Americans.

Before commenting on congressional action or reaction to the long-term health care problem, I would like to applaud the subcommittee for recognizing that the private insurance industry has not been silent on this issue. With every passing month or year, new innovative long-term care insurance products are being developed and marketed.

More importantly, the majority of these products are geared toward combating the most catastrophic of situations faced by older Americans, long-term institutionalized care.

I am pleased to see that the subcommittee does not want Congress to get caught up in the politics of this issue and in the process eliminate the role the private sector must play in addressing this problem. One reason for Congress's inability to deliver effective long-term catastrophic care legislation earlier this year was the lack of a cooperative and coordinated approach.

Long-term catastrophic home health care will not address those who are in nursing homes, but it must be part of any final solution to the long-term catastrophic care issue. Viable catastrophic long-term care legislation must include significant home health care provisions.

As you know, Senator Pepper's catastrophic care bill, H.R. 3436, would have provided long-term health care for seniors as well as children who are chronically ill. I have few doubts that whatever Congress eventually decides on this issue will include much of what Senator Pepper proposed.

In addition, the long-term savings that will result from increased home health care utilization will help mitigate the cost of comprehensive institutional care insurance.

In short, with one we would be able to better afford the other. Allowing mom and dad to stay home with dignity is far less expensive than a nursing home—the end result if we do not expand home health care.

I do not share the belief that a national home health care program, properly coordinated with private insurance policies, would lead to excessive Federal costs, or a dramatic rise in the number of charlatan health care providers. Quite the contrary. The long-term savings of home health care, where family members will continue to provide the lion's share of the care needed, are there for all to see.

Families would also provide the best safeguard against phony home health care providers. Sons and daughters are not about to abandon their parents just because a home health care service is available. Those who believe that sorely underestimate the sense of family most Americans hold dear.

Chairman Stark, you correctly indicated that the fundamental issue here is the balance that must be struck between public and private financing of long-term catastrophic care protection. With careful consideration, I believe that Congress will be able to fashion a comprehensive long-term health care package that does not force older Americans to bankrupt themselves for coverage and allows the private insurance industry the freedom and incentives they need to refine and initiate new long-term-care policies.

I dare say that the outcry that is beginning to be heard by America's seniors against the premium increases they will soon pay for limited, acute illness coverage will force a cooperative effort to be explored and adopted.

Congress owes our Nation's seniors the respect and consideration of providing them with affordable long-term catastrophic health care protection. The traditional piecemeal approach of Federal legislation must not be allowed to occur on this issue.

Long-term health care protection must be total, but affordable; it must be guaranteed, but with choice; and it must be strong, but able to adapt to all health care environments.

Thank you. I would be happy to answer any questions you might have.

[The statement of Mr. Rowland follows:]

STATEMENT OF CONGRESSMAN JOHN G. ROWLAND
before the
SUBCOMMITTEE ON HEALTH
of the
COMMITTEE ON WAYS AND MEANS
August 2, 1988

Chairman Stark and Members of the Subcommittee:

I would like to express my thanks to the Subcommittee for permitting me to testify today regarding an issue of immense importance to the future of our country; the provision of affordable, quality long-term health care for all Americans. You are to be commended, Mr. Chairman, for holding this hearing and I trust it will be a first step toward achieving some answers to this growing national tragedy.

Before commenting on congressional action or reaction to the long-term health care problem, I would like to applaud the Subcommittee for recognizing that the private insurance industry has not been silent on this issue. With every passing month or year, new innovative long-term care insurance products are being developed and marketed. More importantly, the majority of these products are geared toward combating the most catastrophic of situations faced by older Americans, long-term institutionalized care. I am pleased to see that the Subcommittee does not want Congress to get caught up in the politics of this issue and in the process eliminate the role the private sector must play in addressing this problem. I do not think that it is lost on anyone that one reason for Congress's inability to deliver effective long-term catastrophic care legislation earlier this year was the lack of a cooperative and coordinated approach.

Congress had an excellent opportunity to provide long-term home health care. However, as you know, Congress failed to consider H.R. 3436 (formerly H.R. 2762), Senator Pepper's "Medicare Long-Term Home Care Catastrophic Protection Act." I voted for the rule on this bill in an effort to bring H.R. 3436 to the floor for debate and a vote. By voting down the rule, I truly believe that Congress missed an historic opportunity to provide Americans with viable, effective long-term home health care. H.R. 3436 would also have provided long-term health care for children who are chronically ill. I have few doubts that whatever Congress eventually decides on this issue will include much that Senator Pepper proposed.

Long-term catastrophic home health care will not address those who are in nursing homes, but it must be part of any final solution to the long-term catastrophic care issue. On February 29, 1987, Senator John Melcher's Special Committee on Aging issued Volume 3 of its Developments in Aging reports. On page 10 the Committee reported, "[a]n estimated four out of five elderly with long-term care needs live in the community. Only one in five live in nursing homes." This fact alone means that viable catastrophic long-term care legislation must include significant home health care provisions. In addition, the long-term savings that will result from increased home health care utilization will help mitigate the cost of comprehensive institutional care insurance. In short, with one we would be able to better afford the other.

I do not share the belief that a national home health care program, properly coordinated with private insurance policies, would lead to excessive federal costs, or a dramatic rise in the number of charlatan health care providers. Quite the contrary, in fact, would occur. The long-term savings of home health care, where family members will continue to provide the lion's share of the care needed, are there for all to see. Families would also provide the best safeguard against phony home health care providers. Sons and daughters are not about to abandon their parents just because a home health care service is available. Those who believe that sorely underestimate the sense of family most Americans hold dear.

Chairman Stark, you correctly indicated that the fundamental issue here is the balance that must be struck between public and private financing of long-term catastrophic care protection. With careful consideration I believe that Congress will be able to fashion a comprehensive long-term health care package that does not force older Americans to bankrupt themselves for coverage and allows the private insurance industry the freedom and incentives they need to refine and initiate new long-term care policies. I dare say that the outcry that is beginning to be heard by America's seniors against the premium increases they will soon pay for limited, acute illness coverage will force a cooperative effort to be explored and adopted.

Congress owes our nation's seniors the respect and consideration of providing them with affordable long-term catastrophic health care protection. The traditional piece-meal approach of federal legislation must not be allowed to occur on this issue. Long-term health care protection must be total, but affordable; it must be guaranteed, but with choice; and it must be strong, but able to adapt to all health care environments.

Chairman **Stark**. Our next witness will be French Slaughter, the distinguished gentleman from Virginia.

Welcome to the committee.

STATEMENT OF HON. D. FRENCH SLAUGHTER, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VIRGINIA

Mr. **Slaughter**. Thank you, Mr. Chairman.

I commend you for calling this hearing and I appreciate the opportunity to make a statement before the committee.

I have been very active over the past 3 years with regard to the Federal Government's role in health care, particularly as it relates to our Nation's elderly. The problems we are facing in this area are indeed serious, and I have focused on two in particular—namely, the impending financial insolvency of Medicare and the question of how we will finance long-term nursing home care. While I believe Congress must address these issues in a comprehensive manner, I shall focus my remarks on the latter of these two problems for the purposes of this hearing.

The issue of financing long-term care is receiving increasing attention in the Congress, and justifiably so. At present comprehensive long-term-care insurance is not available for the great majority of elderly Americans. Although that is changing, as the number of firms offering long-term care policies has increased fivefold over the last 3 years, this market needs to develop more quickly.

In order to accelerate this development, a number of things can be done at the Federal level. First, an accelerated growth, even the prospect of such growth, in the liquid assets of the elderly would create a stronger effective demand for long-term care insurance.

Legislation I first introduced in the 99th Congress, and which is now cosponsored by 44 of our colleagues on both sides of the aisle, could provide such growth. The primary goal of our bill, the Health Care Savings Account Act, is to put our endangered Medicare system on sounder financial footing by offering Americans a voluntary new savings vehicle in which to save tax-sheltered funds during the working years for use on health care costs in retirement, thereby reducing claims on our scarce medicare trust fund.

Mr. Chairman, I know this issue is not the focus of this hearing, but it is certainly related and I believe it must be addressed immediately, as has been urged in every annual report of the Medicare trustees since I have been in office.

In addition to shoring up our medicare system, the Health Care Savings Account Act could, combined with some of the tax-free rollovers, rapidly increase the resources available to finance private long-term care insurance.

Second, I believe Congress needs to encourage the private insurance industry to expand their long-term care insurance products and make them more widely available. I believe it is extremely doubtful that the Federal Government can solve the problem of financing long-term care without appealing to a substantial degree to the private sector.

Towards that end, I am introducing legislation this week, along with several of my colleagues, which will offer Federal employees the option of purchasing needed group long-term care insurance. In addition, this program will serve as an actuarial model to stimulate underwriters to further develop and market group long-term care policies to a broad spectrum of Americans.

In order to increase the incentive for the 2.5 million active Federal employees to participate in this new long-term care insurance option, our bill would permit those insured under Federal group life insurance at age 50 to convert a portion of this policy to the long-term care insurance program, thereby lowering the monthly premium. This conversion option recognizes the decreasing need for life insurance as one gets older, the house is paid off, and the children are in the working world, as well as the increasing need for protection against the greatest fear of old age, a debilitating illness that leaves one unable to care for himself or herself.

Under the provisions of our bill, the Federal Government's share of the total amount of basic insurance would remain unchanged, because the long-term care insurance option would be financed solely by voluntary employee contributions, with no additional cost to the taxpayer.

By taking the lead in providing a market in this emerging new field, the Federal Government can greatly enhance the development of badly needed group long-term health care insurance policies.

In addition, as Matt stated, a number of improvements need to be made in the Tax Code in order to assist the underwriters and stimulate the demand for long-term care insurance for all Americans, including: establishing a uniform definition of long-term care insurance for purposes of the Internal Revenue Code; clarifying that long-term care insurance reserves are tax deductible like health and life insurance reserves; establishing long-term care insurance as a routine, tax-deductible employee benefit and as an option in cafeteria-style benefit plans; and permitting individuals to convert, on a tax-free basis, life insurance policies and individual retirement account funds to long-term care insurance policies.

Finally, establishing a federally backed, privately capitalized reinsurance corporation would protect primary policy underwriters from excess risk.

These latter changes are all contained in legislation spearheaded by Representative Matt Rinaldo and which I joined in introducing last year in H.R. 3501. I believe these changes are precisely what is needed to induce insurers to bear the startup costs and financial risks of aggressively marketing long-term care insurance on a national basis.

If Congress were to pass the three bills discussed above now, I believe they would result in the increasing availability of group long-term care insurance during the working years, and of comprehensive private insurance policies after retirement which are tailored to each individual's needs.

Should the Health Care Savings Account Act and H.R. 3501 become law today, I foresee a future where individuals will take their HCSA funds upon retirement, go to the private insurance industry, and negotiate for a policy that will not only cover their new responsibilities in the acute care sector, but also long-term care costs. By using such a lump-sum arrangement, these individuals would be able to take care of nearly all their health care needs—

that is, coverage for both long-term care and the gaps in Medicare—with the purchase of one policy at age 65. In the improved environment created by this legislation, such a policy would be affordable to those who have utilized HCSAs over their careers, as the buildup in such an account, even with small monthly contributions, is tremendous. Finally, to the extent these private sector initiatives are successful, the strain on our Medicare trust funds will be reduced, to the betterment of Federal health policy in general.

In order for this scenario to prove correct, I believe Congress must act swiftly to approve these bills in order to build up the savings necessary to substantially reduce claims on Medicare and to expand the availability and affordability of long-term care insurance.

I appreciate the opportunity to share my thoughts with the members of this committee, and I look forward to working with them to alleviate not only the long-term care financing problem, but the projected shortfalls in the Medicare trust fund as well.

Chairman STARK. Thank you, French.

As is the custom of this committee to save the best for last, we welcome our colleague from Oregon, Peter DeFazio.

STATEMENT OF HON. PETER A. DeFAZIO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON

Mr. DEFAZIO. Thank you, Mr. Chairman.

As one of the—as far as I know—two people in Congress with formal training and work experience in gerontology, I hope I do have something to offer.

I am not going to go into great detail on financing mechanisms. I would say that I am comfortable with the extension of the FICA Medicare portion to incomes above $45,000. It makes the tax in some ways a bit less regressive in terms of at least the percentage of income that is paid would be equitable among all levels.

But I would like to address a few of the things that I would like to see the committee address as the substance of the bill not for financing, but in provision of services.

Mr. Regula testified that he would like to see a pilot program. We do have a partial pilot program in Oregon in that we have a title XIX waiver for deinstitutionalization of seniors from nursing homes into the community, in adult care foster homes. This is yet a young experience; in fact, there have been complaints from the nursing home industry, and we are currently investigating to see whether or not the degree of deinstitutionalization that has been put forth is appropriate in all cases.

But I think once we have that investigation in hand, we will find that there has been a great deal of appropriate deinstitutionalization, that we are supporting these people at much less cost to the community in foster homes, and would offer that as a middle alternative.

We have been talking today about in-home care, about institutional care at the skilled level, but we also look at an option which falls between those two, which is a foster home care, which is to some extent certainly less expensive, less restrictive.

My own personal experience is, I have worked with seniors in an institution, Jewish Home for the Disabled in the San Francisco area, and found that there were a number of people, as the statistics show, that were in the institution because of failure to be able to perform one or two daily tasks of living, something that could be provided at quite low cost with appropriate monitoring through the private or public sector.

Second, I worked with the senior companions program, a Federal program which recruits low-income elderly to work with frail elderly to attempt to maintain them in their homes at a very, very low cost. People are stipended. The program is unfunded.

There are many more seniors who would like to work in the program and there are tens of thousands of people who would be served in that program—a potential low-cost option to provide in-home care at a very minimal cost to the Federal Government.

I would urge that the committee not get locked into an all or nothing approach on either end. I think we have had some excellent suggestions in terms of the private-public partnership working with the insurance industry, but also we need to focus a bit on what services it is that we can best provide.

We don't even know yet how many people are inappropriately institutionalized, how much money we could save there. There were estimates of up to $2 billion a year. It could be more or less.

Until we have more pilot programs going, we won't know, so I suggest that we move forward with the in-home portion first to see what sort of savings we can engender. Other countries have a lower rate than we do and provide more in-home care than we do.

The family structure is different; that is another factor, but it is considered to be one of the primary factors. Move forward first with the in-home care and then take up how we are going to pay for long-term care for those who are appropriately and necessarily institutionalized.

I thank the Chairman and would entertain any questions.

[The prepared statement follows:]

STATEMENT OF THE HONORABLE PETER DEFAZIO
U.S. House of Representatives
before the
Subcommittee on Health
of the House Ways and Means Committee

August 2, 1988

When the House voted on the long-term bill, H.R. 2470, earlier this summer, alot of people said it was a good idea but the time just wasn't right. That was simply not true.

The recently passed catastrophic care bill started out as a good idea: come up with legislation to address the problem of catastrophic health care costs currently borne by older Americans. But something went wrong on the legislative road from conception to construction.

The bottom line of the legislation? Everyone pays and few benefit. Of the nation's 32 million Medicare beneficiaries, only four-tenths of one percent will benefit from the provision allowing for hospital stays in excess of 90 days per year. Ninety-three percent of the participants will not exceed the $1,370 out-of-pocket limit on doctors' bills. And 83.2% will never exceed the $710 deductible on prescription drugs.

In order to pay for these minimal health care improvements, existing Medicare premiums will increase by 41% between now and 1993. Many Medicare recipients are already hard pressed to pay the 38.5% increase the Reagan administration imposed last year.

Elderly who live alone have much higher poverty rates than do persons living with a spouse or with children. In 1980, people over age 85 and living alone had a poverty rate of 36.8 percent, in contrast to 12.4 percent among those living with a spouse. In addition, women have rates that are two to three times higher than men.

Many of these senior citizens don't seek medical attention because they don't have the discretionary income to meet their insurance deductible. The catastrophic care bill did nothing to aide those with the highest rates of poverty. Thus, continuing to deprive those who need assistance the most and offering little or no relief to the chronically ill and disabled.

Over 80% of catastrophic care expenses are incurred outside the hospital. Roughly, 5% of those age 65 and over are in nursing care facilities at any given time. Those over age 85 have more than a 50% chance of spending time in a nursing home during their remaining years.

The age 65 and over population will more than double in the next 30 years, while those age 85 and over, will almost triple during the same time period. With nursing home costs averaging $25,000 a year, 7 in 10 elderly living alone spend their incomes down to the federal poverty level in 13 weeks. Government and families then have to bear the burden of supplementing the nursing home stay.

Currently, 5.2 million people over age 65 are disabled enough to need help with day-to-day tasks such as food preparation, dressing and bathing. Adequate home care coverage would help keep seniors and disabled out of nursing homes where they can receive more appropriate care at a lower cost.

These citizens still make valuable contributions to society. Home care provides those individuals assistance with a few daily activities, and yet, preserves their sense of independence. These citizens can more readily maintain their ties to family, friends, and community from their own homes.

Other provisions that are desperately needed by the chronically ill are: homemaker and home aide services; medical social services; comprehensive vision, hearing and dental care; complete coverage for prescription drugs, and patient and family education, training and counseling.

I support the financing mechanism in H.R. 2470, which would remove the cap on the Medicare payroll tax, currently set at $45,000. Applying the tax to the wealthiest 5% of Americans, those who earn more than $45,000, would raise more than $7 billion every year. This is a flat tax, which would impose no additional cost on the 95% of American workers who earn $45,000 or less, and would be regressive for the 5% who do earn over $45,000 a year.

A poll by Lou Harris and Associates, conducted in February, 1988, found that 73 percent of Americans earning over $50,000 a year, favor extending the payroll tax beyond $50,000 a year to pay for the bill.

In turn, this would save the federal government more than $1.9 billion in savings from poverty assistance programs that currently bear the costs of long-term care.

To prevent cost overruns, when a shortfall is projected, Medicare will bring costs down to the level of revenues by imposing a copayment on beneficiaries, and reducing the maximum monthly benefit.

There is no excuse for the fact that 60 million Americans lack adequate health care. We need a bill that contains real coverage for out-of-pocket medical costs, prescription drugs, hospitalization, and long-term health care.

H.R. 2470 is a good bill and the time is right to enact relief for our citizens, young and old, who suffer from chronic illness and disability.

Chairman **Stark**. It falls to me to have to correct a few parts of your testimony.

First, you may be one of two people trained in gerontology, but the nine members of this subcommittee have a laboratory, having to take care of Congressman Pickle and myself, which no gerontology school would qualify.

I would suggest to you that the members of this subcommittee have a great deal of experience in caring for the elderly and I must say they could do a great job.

In your testimony, you stated a couple of things with regard to the catastrophic bill. I will go over those quickly. The debate on the question of who should pay has gone round and round, but I think that the subcommittee determined that the benefit in the so-called catastrophic bill was not the payment to people who get sick. But rather the removal of fear. You don't buy fire insurance to get a benefit when your house burns down; you buy fire insurance in case it does.

All 32 million Social Security beneficiaries receive a benefit and I think they would all stand up to say that the other guy should get the catastrophic bill. That is an argument, but I wanted to respond to that.

Second, while it is not much in my province to defend the Reagan administration, the increase last year on the part B, first of all, was designated by law. I don't think they could have done much else. We could have postponed it. Most of the increase of that 38 percent was playing catchup for 3 or 4 previous years when they held down the increase.

Mr. **DeFazio**. They did change some assumptions.

Chairman **Stark**. Yes, but basically we knew they were doing that, and I think you would have to blame our subcommittee as well as the administration. We knew the rates weren't going up as fast as they should and they had to in the last year. I just suggested that.

Then there was the catastrophic bill, but you suggested nothing to aid those with the highest rates of poverty. We certainly may not have done enough.

We did require a mandatory buy-in by all States, but Oregon and California wouldn't be covered under this because they already do the right thing. But for many States, the poorer ones in the United States, requiring the mandatory buy-in for Medicaid for all beneficiaries was of great benefit to the very poorest.

I wanted to, on behalf of the subcommittee, suggest those as responses, maybe not answers to your otherwise useful and constructive testimony.

Mr. **DeFazio**. If I could for a moment go back to the fear, it may be fear of some of the members of the subcommittee you mentioned we have experience with the aging process themselves, and maybe a fear among some segments of society. But what I hear from the seniors in my community is not the concern, what happens to me after the 90th day in the hospital, because most figure they will be dead. That is not the fear weighing heavily on their minds. Long-term care I think is one that has weighed heavier.

Chairman **Stark**. If their fear isn't that, and maybe Oregon doesn't have Lorne Greene and Danny Thomas on late-night television, then why are 70 or 80 percent of them buying the medigap policies? My mother has eight of them. She is scared to death.

In a sense, I respectfully suggest that this broad coverage by medigap is what we tried in a sense to replace. However, the seniors in my district are very unhappy about paying more money, and I think we are going to hear more from them next year.

So I don't suggest that you are incorrect when you say there is a lot of grumbling out there, but I think in time you will find the new system is more fair.

Mr. **DeFazio**. The docket is long, and we may differ there.

I would also like to point out on the catastrophic, that I really see the deductibles as a problem, that many low- and middle-income seniors will not go to the doctor because they can't afford that first $1370. They will avoid preventive care, timely care, just because of those bills.

So I don't think even if all else is accepted, that we have solved the entire problem with those large deductibles in place.

Chairman **Stark**. I think this committee would join with you unanimously on the day when we have a balanced budget to pay for first-dollar care or a very modest deductible if we could, but that is the most expensive part of the program.

Mr. **DeFazio**. Thank you, Mr. Chairman.

Mr. **Donnelly**. I have a generic question and anybody can answer, or disagree.

Do any of the panelists disagree with the assumption that as we go down the road to establish a long-term care benefit for Medicare beneficiaries, that we are going to have to factor in people's ability to pay; that obviously unlike the catastrophic benefit, we will have to seek out other sources of revenue to pay for this, whether it be the payroll tax, estate taxes or whatever.

Obviously some of the costs will have to come from the beneficiaries, and part of that cost ought to be related to people's ability to pay. The elderly are not an economically homogenous group. They have a disproportionate share of poverty, but there are some who have substantial assets.

Is there a disagreement—that is where I am coming from—is there disagreement from any of the panelists on that?

Mr. **Kleczka**. I think one of the major problems with the Pepper proposal was the fact that instilled in that legislation was no ability to pay whatsoever, no copay on the part of the person receiving the long-term home health care.

As we move forward, this committee will probably be the moving force in a long-term home health care bill and nursing home bill that will have to be one of the components to funding the measure. Clearly one of the other components will be lifting the cap on the medicare tax.

And I think it was mentioned before by one of the other members, talking of the sin tax, clearly there is too many sins around here for the sin tax, and that would not raise substantial revenue needed for this proposal. Sin tax could be used to plug little holes, but clearly not fund big proposals like this.

That is why I think one of the significant pieces of the Mitchell bill was the inheritance tax, which I think was the place to go.

Mr. ROWLAND. I would not agree. I see some progressivity in Senator Pepper's bill, because going after those with incomes of more than $45,000, you are in essence going after those with ability to pay in order to fund his particular bill.

You and the Ways and Means Committee.

Mr. DONNELLY. Those are the taxpayers, not the beneficiaries.

Mr. ROWLAND. But you are going past the beneficiaries, there is no question about that.

You raised the question that none of us want to answer either, on the full committee or the Congress, but it is a reality. Every one of us has experienced the full situation in the senior centers and talking in town hall meetings. Seniors raise their hands and indicate they want an increased coverage. You then say that is fine, we will give you whatever you would like as long as you are willing to pay for that or, going a step further, if you are willing to have your children pay for that. Then you get a different response.

About 70 percent of the seniors buy medigap policies, but that is because not only are they worried for themselves, but many of them are parents and they are greatly concerned about passing that bill and that debt on to their children.

I think that is a bigger fear than their own death. If they are going to die within 60 or 90 days, they don't want to pass debt on to their children. They have taken care of them all their lives and they don't want to leave the debt to the beneficiary.

Mr. DONNELLY. Long-term care coverage will provide access to care but it also at the same time provides asset protection. You are protecting the depletion of those assets so that people do not have to become impoverished for these Government programs.

I don't think, under the present budgetary restraints that we have, that we can create another entitlement program without putting in a mechanism that takes into account people's ability to pay. It is not politically popular, but I think it is fiscal reality.

I am not talking about a confiscatory system. You can do it through premiums or in the Tax Code, similar to what was done in the catastrophic health bill. I wanted to make that point.

I appreciate you all coming and I think long-term care is going to happen, because there is real strong support in the House for it.

Thank you.

Chairman STARK. Mr. Pickle.

Mr. PICKLE. I have questions to ask the panel, particularly those advocating private insurance. That may be one approach we will take.

Have you cost-factored out the cost of private insurance? If an individual takes out a private health policy, would his premium be, based on the bill you have introduced, $50 a year or $1,500 a year?

Have you set any amount of what the premium would be, and if you did take that insurance out as a private policy, is it your proposal that it would be a tax credit or something that he can deduct from his income tax?

Second, I noticed that some of you advocated giving a deduction to heads of households if they take care of the family.

Mr. Bilirakis, have you cost-factored that? Do you know what that would cost on an estimate?

Then you recommended that you would give a tax credit in the form of charitable contributions for the doctors and nurses who contributed time. What is the cost of that approach?

Last, you recommended that you would give an employer credit if he sponsored retiree health plans for the employees. What is the cost factor of that?

Have any of you got any estimates of what the costs would be in any of those four categories?

Mr. BILIRAKIS. I am glad you asked that. I don't know what we will hear from the others, but I imagine probably similar to what we heard from a previous panel, and that is that we are not getting any cooperation at all from the Treasury or the Joint Committee on Taxation.

We talked previously about the task force that I chair and other task forces. That was the big thing—that we were not getting those figures. How can we make a proposal without those figures? We would be in dead center unless we did something.

Mr. PICKLE. You have asked Treasury and they would not give you any?

Mr. BILIRAKIS. That is exactly right.

Mr. PICKLE. That is what this committee needs. If you give a tax credit for private insurance, which may be desirable, and then turn around and give them credit, that is paying Peter and Paul. If you give an employee credit, that is going to cost like sin.

So will the private premium be enough?

I guess we won't know until you get some figures. We need to have those figures.

Mr. BILIRAKIS. When we are talking about the head of the family taking care of their elderly, that is the sort of thing that, before Medicare took place, we were glad about—we took care of our families.

Now we are talking about the deductions over and above the 5 percent threshold. But that is only for the expenses that are incurred, if you will. There is no deduction for the time, in other words, that the son or daughter puts in for the parent or grandparent—the head of the household.

You are going to have quite a saving, as far as that is concerned, I should think. But I certainly cannot quarrel with your point.

When you talk about the cost of premiums for insurance, I think Matt Rinaldo testified about figures earlier. I know he has gotten figures from certain insurance companies and, unless they are bound to those figures, it is difficult to go too much further as far as that proposal goes.

Again, he doesn't know what it would cost the Treasury insofar as some of these tax benefits we would give the companies—because the Treasury has not been helpful to us.

Chairman STARK. Have you specified that here is a bill we want to recommend for passage, and Treasury or Joint Taxation has not given you answers? Have you asked them specific questions?

Mr. BILIRAKIS. Going back to the latter part of last year when we introduced the legislation.

Mr. ROWLAND. One of the great difficulties is the whole theory of insurance, spreading the risk, in other words, collecting a great deal of money from many individuals and benefiting just a few.

With regard to long-term health care, or home health care, it is increasingly difficult to estimate what the costs are going to be. Long-term health care increases on a yearly basis. You never know how many people will use it and what they are going to use it for.

All insurance companies are in the business to make money, so they will look carefully until they change those benefits. Until they see that they will collect enough money to turn a profit and still pay the benefits, they are not going to make good products available.

I think that is hopefully where the collective effort is made with the Congress.

Mr. SLAUGHTER. There is a study going on about some of the things we have talked about today. I don't know the status of that. It should have been complete by now.

If I can find out any information on that, I will certainly let you know.

Mr. PICKLE. I would simply point out, as you and I both know, this committee has to find out what the costs are. It is good to recommend the various approaches from all the various bills, but we have to know the costs.

If Treasury or Joint Taxation is not being responsive to specific requests, then we will enter into that discussion ourselves to find out why. But we will have to know that.

The temptation is great to give tax credit if they do certain things. But you know, when we had Social Security, one of the proposals was that if you don't need your Social Security, don't take it, and you get tax credit for it. That sounds very good but it is a question of Peter and Paul. You might give a tax credit to an individual and take more out of the Treasury. If you are not careful, you will give more credits than we have funds to pay for. That is the problem of the committee.

Well, I thank you very much.

Mr. LEVIN. This has been a particularly effective hearing and this panel certainly so.

I just have a couple of comments about this panel and their testimony.

I think most, if not all of us, favor partnership between the public and private sectors. I think all of us really need to dig into what the private sector might provide.

As I mentioned earlier, I have been struck as I have tried to look into the rudimentary nature of most, if not all, private insurance policies for home health care.

Mr. DeFazio, you suggested a phase-in, as I understand it. I think one thing the subcommittee and then the full committee will look into is whether we want to elevate coverage step by step or try to do it all at once.

There are some unknowns here. They should not scare us off. We ought to try to be as informed as possible as we move into this critical area.

Thank you, Mr. Chairman. It has been an excellent hearing.

Mr. MOODY. I would like to ask each of the panelists a couple of things about structural features.

Do each of you agree that it should be deficit neutral? Is there any disagreement with that?

Mr. **SLAUGHTER**. It depends on which plan gets knocked out. There will be some that inevitably will be deficit neutral to begin with.

Mr. **MOODY**. You do not envision a plan that would be a major drain on general purpose funds?

Mr. **SLAUGHTER**. No.

Mr. **MOODY**. So it will be self-financed.

Mr. **SLAUGHTER**. If you give them credits for health care, you will automatically lose in the beginning. Over time, however, I think it costs the Government less than it costs them now.

Mr. **BILIRAKIS**. I would endorse French's remarks. When you talk about credits, you are talking about money that will not go to the Treasury.

When you have encouraged the family to take care of their elderly, you certainly result in savings—a hell of a lot more than you would if we basically get away from that, which is what we have done in the last 20 years, I am sure you will agree.

The same is true of medical doctors. When you have the households, even though there is a charitable contribution deduction there, still you are talking about ultimately cheaper medical care—I would like to say of a better quality too.

But unless we have these figures, it is difficult for you to digest and difficult for us also.

Mr. **MOODY**. We have a goal of deficit neutrality overall. You can achieve that with tax expenditures, even if other aspects of the program run surpluses to carry the cost of the tax credits.

Do you assume any premium revenue at all?

Mr. **BILIRAKIS**. Yes. Again we are talking about joining together or blending together and making a supper stew from all these proposals and coming up with the best idea.

As John and Matt said before, if we are talking about giving affordable plans to the insurance industry, then we are talking about affordable-type plans to the taxpayers, not the Federal Government—to the beneficiaries.

So, yes, you would have some revenue coming into that.

Mr. **MOODY**. The next question is whether it should be generationally neutral, that is, whether each generation should pay for itself, as with catastrophic health care.

In other words, will the beneficiaries pay for the benefit or should it be generationally non-neutral?

Any of you can comment.

Mr. **KLECZKA**. Because of the expenditure, I think we would have to cross generation. Those who earn in excess of $45,000 would be funding it in part.

I see no problem paying for a program the seniors say they will utilize. If you want a sink proposal, go for it. Some of those proposals will find the fiscal drain on our Treasury is more than we can stand.

As far as setting up an IRA type of plan for medical expenses, every time there is a budget crisis we start talking about that. For those who cannot afford the first home, let's support an IRA for that, then one for education and health care. There is one in existence for retirement.

The problem with all these IRAs is that many of my constituents don't have the net take-home pay to fund them. Forget them. They are pie in the sky. I don't buy all that nonsense.

Mr. **Moody**. The Pepper bill covered chronically ill children and some other things such as spinal cord injuries.

Mr. **Bilirakis**. If the Federal Government is going to be involved—you are talking about that particular category—those that can should, and those that cannot should be helped.

Mr. **Kleczka**. If we don't provide home health care services for this individual in title XIX, it will cost more in the nursing home or institution.

In looking at the Pepper bill, we found they could be higher than a nursing home, but I think they would be less.

Mr. **Moody**. For the nonelderly?

Mr. **Rowland**. I would support support for all ages of chronically ill.

The question of a needs test may also come into play. You know, with many of the accidents and chronically ill young people as a result of accidents, there may be other income, that is, lawsuits, that could help.

Mr. **Moody**. How about asset taxes or inheritance taxes? It is part of the Mitchell and Obey plan. It is what Brian Donnelly pointed out about asset taxes.

Do you feel the assets should be a factor on the revenue side or not?

You mentioned a man might receive a settlement for an accident. That is an asset. Someone else may own a wealthy estate. That is an asset.

Do you think they should be brought in?

Mr. **DeFazio**. Look at the inheritance test but be careful with assets, because it was suggested to put liens on people's homes for Medicaid recipients who were institutionalized and also liens for people who went in on a tax deferral program. That made the seniors very reluctant to utilize these programs, because they did not want to see their entire estate confiscated on their death.

I would do it in a way that does not seem so confiscatory, but dealing with the inheritance tests——

Mr. **Moody**. There is a recognition in the Mitchell bill that assets be protected.

Does that bother you?

Mr. **Rowland**. It bothers me. I have not examined all the provisions in the Mitchell bill, but one other major concern has to be the other spouse, the remainder of the family.

One of the mistakes in the medicaid program is that we require the individual or couple to be devastated to $1,500, for argument's sake, and then you have someone with long-term health care in a convalescent home and the surviving spouse is devastated economically.

Mr. **Moody**. I am talking about whether the assets should be part of the cost.

Mr. **Rowland**. It should be in the calculations, yes.

Mr. **Moody**. Does anyone disagree there should be an exclusionary period? There is one in the Obey-Mitchell bill. Does anyone object to that?

Mr. KLECZKA. The problem in the Mitchell-Obey bill is that the exclusionary period is a 2-year period. It is rather lengthy. It recognizes the cost to the Federal Government and the taxpayer to make the thing balance. Clearly if that cannot be reduced and funded, then the insurance industry could put up that part of the time.

Mr. MOODY. We will need something to fill that gap. If not, Medicaid would fill it.

Mr. BILIRAKIS. Wouldn't it depend on need? A truly needy individual will have great problems with an exclusionary period and have problems with the insurance premiums. But there are a lot of people out there who are not truly needy and do not have those problems.

I might also add here, going to your previous point, that I am not that concerned with what the parents want to put aside and save for their children, quite frankly. I don't think they owe their children. They owe them to get them to a certain point. I have seen too many cases as a practicing attorney in the elderly area where people would come in and transfer their assets to the children and then the next day go after food stamps.

That sounds terrible. Where is their dignity and pride?

But I am telling you it is done, and it is done quite a bit. I am concerned with protecting persons, but as far as impoverishment, I don't think we ought to be mortgaging their homes or farms, but once they are gone I am not interested in protecting assets.

Mr. MOODY. Insofar as premiums are utilized on the revenue side, do any of you have trouble with a means test in this bill? Does anyone object to this in the bill?

Mr. DEFAZIO. That depends on the level that you choose.

Mr. MOODY. Thank you.

Chairman STARK. Thank you.

I would like to thank the panel very much for your contribution.

[Whereupon, at 5:10 p.m., the subcommittee was adjourned.]

LONG-TERM CARE INSURANCE

THURSDAY, AUGUST 4, 1988

House of Representatives,
Committee on Ways and Means,
Subcommittee on Health,
Washington, DC.

The subcommittee met, pursuant to call, at 10:20 a.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

Chairman Stark. The Subcommittee on Health of the Committee on Ways and Means will begin its hearing on long-term care. This is the first step in developing long-term care legislation.

First of all, I would like unanimous consent that this lengthy opening statement be put in the record in its entirety. Without objection, I will paraphrase a good bit of it.

[The statement of Chairman Stark follows:]

THE HONORABLE FORTNEY PETE STARK

Opening Statement at Hearing on Long-Term Care

Subcommittee on Health
Committee on Ways and Means
August 4, 1988

Today the Subcommittee begins its work on developing long-term care legislation.

It will be a difficult task, but I believe that our work will lead to enactment in the 101st Congress of a law providing protection against the costs of chronic illness and long-term care expenses.

The cost of long-term care has become a major issue to our elderly. These people, who expect to enjoy a moderate standard of living during retirement, fear that they will be reduced to near poverty if they are ever forced to pay for expensive long-term care services.

Their concern is well founded. Nursing home care now costs over $25,000 a year; even home health services can cost $1,000 a month. And the vast majority of the elderly do not have any insurance against these costs.

Medicare does not, as we all know, cover long-term care services. And private insurance, by health insurance standards, is almost non-existent.

Medicaid does cover long-term care but only after a lifetime of assets is exhausted.

So the options are bleak: Private payment without the support of insurance or Medicaid spend down and poverty.

It is not surprising that this has become a major issue to our elderly and their families.

The problem will grow in the years ahead.

With falling mortality rates and the aging of the baby boom generation, the elderly population will increase substantially in the future. The total elderly population is projected to increase from 31 million in 1986 to 50 million in 2020.

More important for long-term care, it is the 85 and older population which is most likely to require long term care assistance. The age 85 and older population will more than double between 1986 and 2020.

Our current system of financing and organizing long term care is not working.

Unfortunately, recognizing that this problem exists does not mean the answers are self evident. Quite the contrary. Within the long-term care area, the choices are complex and difficult.

In beginning its work in this area, the Subcommittee will need to identify the essential elements of a national long-term care policy.

The first issue to be addressed is the types of care that should be covered. Should a program cover only home health care as suggested by Senator Pepper's bill or should nursing home services be included as well?

The answer may be that when we hear about long-term care from our elderly constituents, the questions are about nursing home care. The bills that are displayed at town meetings are nursing home bills. I know many Members were surprised to learn that the Pepper bill did not cover nursing home care.

A second set of questions deal with striking the balance between a public program like Medicare and the role for private long-term care insurance.

A fully funded public program would be very expensive. A balance between public and private insurance would reduce the Federal costs of a program. Some, of course, would like to see the private sector meet all our long-term care needs.

But long-term care may not be the type of service that can be privately insured for a significant segment of the population.

Long-term care insurance doesn't fit the Medigap model. All of the elderly need physician and hospital services and so most people over 65 are anxious to buy Medigap insurance. But, since most long-term care is used by those over age 85, most of those in the age 65 to 85 group won't use their often meager incomes to purchase long-term care insurance that costs as much as $1,200 to $3,000 a year.

Insurers, of course, do not usually want to sell policies to the over 85 age group nor could many of this group afford the very high premiums for coverage if they did.

Long-term care insurance more closely fits the life insurance model. It needs to be financed over a period of decades beginning with the middle years.

Yet much of the working age population feels they are already "insuranced out" after paying for health, car, house, life and disability insurance.

Further, employers are not a likely source of long-term care insurance for the vast majority of the elderly. Only 20% of the elderly now have employer-based acute care Medigap insurance. And employers today seem more interested in reducing, rather than expanding, fringe benefits.

Some believe tax incentives for private long-term care insurance will solve many of the problems. However, this may only help the affluent. Only 20%, mostly the very affluent, bought IRAs.

And we should not underestimate the loss in revenue to the Treasury. A tax incentive program proposed as a way of reducing public costs could result in a large increase in the Federal deficit.

The Subcommittee may conclude, as Drs. Joshua Wiener and Alice Rivlin did in their Brookings study, that a long-term care program will only work if it is a publicly based program like Medicare.

If a Medicare type long-term care program is considered, then several more questions must be answered:

* What types and levels, if any, of beneficiary cost sharing -- deductibles, waiting periods and coinsurance -- should be included?

* How can we balance an adequate supply of high quality nursing homes and home care agencies with reasonable payments?

* How should eligibility for benefits be determined?

* Who should manage patients through the many types and levels of care?

While these are tough issues, they don't begin to compare with the difficulty of the decisions the Subcommittee will face in deciding how to finance benefits.

Increasing the estate and gift tax may be the most appropriate source of revenues.

Medicaid, our current national long-term care program requires individuals to spend down their assets. And people who have been in a nursing home longer than twelve months rarely leave. Therefore, some may argue that the spending down of assets is appropriate.

A new Federal long-term care program would, among other benefits, protect assets for children and other heirs. An estate and gift tax would pool these costs. It would be far more equitable and progressive than the current patient financed system.

A 10% surtax on estates would raise $5 billion a year.

The cap on earnings subject to the Medicare portion of the payroll tax could be removed as proposed by the Pepper bill.

This would be a progressive tax paid only by those with the highest incomes. While some would say this violates the "social insurance" basis of Medicare, it would raise about $7 billion a year.

Another revenue option would be to increase the payroll tax.

This may be the only way to raise sufficient revenues to cover costs of over $20 billion a year or more. An increase of the HI payroll tax of .35% on each the employee and employer would raise about $10 billion in 1989. Without a wage cap, it would raise $12.5 billion.

Requiring all State and local government employees to pay the Medicare portion of the payroll tax could contribute about $2 billion a year to the costs of long-term care.

Finally, beneficiary payments may have to be included in the revenue equation. The Part B premium could be further increased, although it will already be more than $40 a month in 1993 to help pay for acute catastrophic coverage.

Medicaid offsets also need to be factored into any long-term care program. Medicaid now spends over $18 b a year on long-term care; this is split roughly 55% - 45% between the Federal and State governments. A Medicare program would replace most of these costs.

These off-sets could be used to cover cost-sharing for the indigent, as provided by the Medicare catastrophic coverage bill, or for other purposes.

A final issue is what features of a long-term care program might be enacted first if it is not possible to do everything at once?

Since a comprehensive long-term care program might cost up to $50 billion a year, benefits may have to be phased-in.

We have, of course, begun this process by adding over a billion dollars a year in new long-term care benefits in the Medicare catastrophic program.

All in all, the Subcommittee faces many difficult and complex choices in the months to come. This will require a long and difficult process. We are prepared to take the time.

In the end, as with the Medicare Catastrophic bill, I believe the Subcommittee can fashion a program that is fair and efficient and will meet the needs of our nation's elderly and disabled.

Chairman **Stark**. We have a difficult task ahead of us. Long-term care, for a variety of reasons, has built itself into a major issue, primarily among our elderly, but also among some of us in the pre-elderly generation. The concern is well-founded.

The nursing home care runs as high as $60,000 a year, and it averages around $25,000, and when probably two-thirds of our 30 million Americans don't have $25,000 a year in income, the magnitude of the problem becomes very apparent.

Medicare was never intended to cover long-term care or custodial care or nursing care, and that is important to remember. Medicare was designed in 1965 to be a medical payment, doctor's bills, hospital bills and now prescription drug bills for people who had an acute illness or sickness. It was not designed to be an income supplement, which is really at the base of any long-term care program.

The problem, we all know, will grow in the years ahead. The elderly population is predicted to increase to 50 million by the year 2020; 85 and older will more than double in that same period.

We will hear from the insurance industry today, but almost without exception, no one sells insurance to people over 80 years old. So, there are a variety of issues.

The first issue is the type of care that should be covered. Should a program cover only health care, as suggested by Senator Pepper, or should nursing home services be included as well? Should there be supplements to family members who provide this care? I know that many Members were surprised to learn that the Pepper bill did not cover nursing home or rest home care.

The second set of questions will deal with striking the balance between the Federal program of federally financed program like Medicare, and the role for private long-term care insurance or other types of subsidized individual savings programs.

A fully funded public program would be very expensive. We have seen estimates running from 20 to in excess of $50 billion per year. A balance between public and private insurance would reduce the Federal costs, and some would like to see the private sector meet all of it. But long-term care may not be the type of service that can be privately insured for that two-thirds of the senior population who are in the low- or middle-income groups.

Insurers, of course, do not usually want to sell policies to those over 85, and this could be a group that would be exposed. Long-term insurance more closely fits the life insurance model. It needs to be financed over a period of decades, beginning in the middle years.

However many of our working-age population feel that they are in the vernacular, insuranced out, car insurance, disability insurance, and I might add, their Federal payroll deductions. They feel like there isn't much more room. Employers aren't willing to step up to the bar, I don't suppose, and increase their employees' base benefit costs. They are going through a lot of agony right now, trying to decide whether they have adequately funded the health care costs for their retirement benefits, much less wondering about whether they can afford an additional benefit.

Some believe that tax incentives will solve the problems. We think that this will really only help the affluent. Perhaps only 20 percent of the population bought IRAs, and they were mostly the very affluent.

If Medicare long-term care is considered, several more questions have to be answered. What levels, if any, of beneficial cost-sharing, deductibles, waiting periods, co-insurance, how can we balance the adequate supply of high-quality nursing homes and home care agencies with reasonable payments?

How should eligibility be determined, and who should manage the patients through the types and levels of care? The Federal Government, State government? These are tough issues, and they don't begin to compare with the difficulty of the decisions we will face in deciding how to finance this.

Step 1, what are we going to provide? Step 2 gets to be rough. We are being beaten around the ears right now for our last venture into this field, and the mail from people who were objecting to paying for catastrophic care is voluminous. I suspect it will go up when they get the bills.

If we talk about increasing the estate gift tax, which many of us think is an appropriate course, I can hear the screams and howls from those families who have already been before this committee looking for exemptions from that tax. As a new Federal program, it would, among other benefits, protect assets for children and other heirs, an estate gift tax would pool those costs. It might be very equitable.

The cap on earnings, subject to the Medicare portion of the payroll tax, could be removed, as suggested by the Pepper bill. It would be a progressive tax paid only by the highest income.

Another option would be to increase the overall payroll tax. This may be the only way to raise sufficient revenues to cover costs over $20 billion a year or more. Requiring all State and local government employees to pay would add a couple billion dollars a year, but we have bet on that course over the past couple of years.

Beneficial payments may have to be included in the revenue equation. It could be further increased. But it will already be more than $40 a month in 1993, and as I indicated earlier, we are hearing some grumbling from people, from the seniors who receive the benefit in paying for it.

These offsets that could be used for cost sharing, for the indigent, or using offsets, could be used for paying for the indigent as provided in the catastrophic bill. Let the higher income people pay more.

Whether we can sell that politically or not, I don't know. All in all, we face a lot of difficult and complex choices. And we are prepared to take the time and let everybody who has an interest in this advise us.

I would urge all of the witnesses, and some of the questioning from other members may focus on it, the focus of the witnesses are well-known to the committee. And it doesn't help us a great deal to have it explained to us that seniors would like to pay as little as possible, that seems to me to be a given.

What would be of help to us to know is, are the seniors willing to do battle to raise the inheritance tax or are the seniors willing to battle to help pay for prenatal care, which is an issue that many Members who don't sit on this panel have a strong interest in and will be pleading before the Budget Committee.

The areas that people are willing to trade off—will the insurance pay a little higher income tax from the profits they make on long-term care insurance to help us fund those people who can't afford insurance? These are the kinds of suggestions that would be a bit of fresh air before this committee, and we would look forward to people joining in with us.

I am pleased to welcome as our first witness a gentleman who I think will shed a great deal of light on the options before us, and I am sure will also give us some excellent suggestions as to some of the paths we might follow.

Dr. Joshua M. Wiener is the senior fellow of The Brookings Institute, who has published a thorough study on this issue. I want to welcome Dr. Wiener to the committee. Please proceed in any manner you feel comfortable. Your prepared statement will appear in the record in its entirety. If you would like to expand on it, or summarize it, you may.

Before you begin, I might ask whether any of my colleagues have a statement that they would like to make?

Dr. Wiener, proceed.

STATEMENT OF JOSHUA M. WIENER, SENIOR FELLOW, THE BROOKINGS INSTITUTION, WASHINGTON, DC

Mr. **Wiener**. Thank you very much, Mr. Chairman, it is a pleasure to be here today.

In May of this year, the Brookings Institute published a book called, The Caring For the Disabled Elderly, by myself and Alice Rivlin, which addressed a number of financing options for long-term care. We would be happy to make the book available to any member of the committee who is interested. My testimony summarizes the 3 years of effort that went into the book.

The basic problem is that the United States does not have, either in the private or the public sectors, satisfactory mechanisms for helping people anticipate and pay for long-term care.

The disabled elderly and their families find, often to their surprise, that neither medicare nor private insurance covers the costs of long-term care to any significant extent. Instead, the disabled elderly must rely on their own resources, and when those are exhausted, turn to welfare in the form of medicaid.

The aging of the baby boom generation, combined with rapidly falling mortality rates for the elderly, will lead to sharply increased demand for long-term care that will require substantially greater public and private expenditures far into the next century.

We project that over the next 30 years, the number of people in nursing homes will increase by 76 percent, that in 1987 dollars nursing home expenditures will triple, and that the percent of the gross national product devoted to long-term care will increase from 0.82 to 1.42 percent.

Before additional stress is put on our already inadequate system, Americans should consider alternative ways of financing long-term care and the potential role of the Federal Government in it. We looked at a very wide range of alternatives for long-term care financing for the future.

We first focused on several widely discussed private sector financing initiatives. These included, first, increasing incentives for private savings by creating so-called individual medical accounts, savings accounts earmarked for long-term care, that would receive favorable tax treatment by the Federal Government.

Second, increasing the ability of older people to use the equity accumulated in their home, which is normally their principal asset to pay for long-term care through home equity conversions.

Third, the pooling of the risk of high, long-term care expenditures through private long-term care insurance.

Fourth, the establishment of continuing care retirement communities or residential complexes with independent living units for older people, and the guaranteed availability of care for the lifetime of the residents.

And finally, we looked at the formation of so-called social health maintenance organizations, an extension of the health maintenance organization concept of prepaid health care financing to include long-term care.

Basically, our projections found some good news and some bad news. The good news is that our projections indicate a substantial potential for growth of private sector financing mechanisms for long-term care. A potentially multibillion-dollar market is almost entirely untapped. People purchasing those products will have better protection against the catastrophic cost of long-term care.

The bad news is that even under fairly optimistic assumptions about who would participate, they cannot be relied on to do the whole job. For example, we estimate that 30 years into the future, by the year 2018, private long-term care insurance like that currently sold to the elderly, age 65 and older, may be affordable by between 25 and 45 percent of the elderly, may account for between 7 and 12 percent of nursing home expenditures, and may reduce Medicaid expenditures by 1 to 5 percent.

These general conclusions also apply to individual medical accounts, continuing care retirement communities and social health maintenance organizations. Home equity conversions and private insurance sold to people under the age of 65 are the principal options we examined where a significant majority of the elderly might participate. However, health equity conversions have limited potential for paying for large home care bills directly, and 30 years into the future, private insurance sold to people under age 65 might pay for only 17 percent of nursing home expenditures.

Private-sector options have a limited impact for two basic reasons: First, they are so expensive that most elderly cannot afford them. Second, while private long-term care insurance policies are rapidly evolving, they currently have a lot of restrictions. Restrictions mean that the policies are limited in the amount of financial protection that they offer.

So, while it is desirable for the private sector to play a much larger role in financing long-term care, our projections indicate that it is not reasonable to count on private initiatives to make the public sector wither away.

The question then becomes, what do we want our public sector programs to look like? And there, I think our basic choice is between sticking with basically a means-tested welfare program as our principal way of paying for long-term care, or enacting a program of social insurance.

The principal argument for staying with a means-tested approach is that Medicaid, despite its limitations and deficiencies, meets the most urgent needs of the elderly population at minimal cost to the taxpayer.

Although incremental improvements in Medicaid are attractive, and I would support them, public charity always carries some stigma, and efforts to reduce taxpayers' costs are likely to continue a two-class system.

Moreover, it is a rather bizarre welfare program where the financial requirements are met by a majority of the people using services. Most people who enter nursing homes come out as welfare patients, medicaid patients. When we think of our other welfare programs, such as aid to families with dependent children and the supplemental security program, only a small percentage of the population is expected to be eligible.

It would be preferable to recognize that long-term care is an insurable risk for the elderly which should be covered by Medicare and not Medicaid. Everyone should contribute to public long-term care insurance and earn the right to benefits when they need them, without having to prove impoverishment. There should be a significant role for the private sector.

Now, the taxes necessary to pay for such a program would be substantial, but they need not be unmanageable. It is important to remember that most of the cost associated with a public insurance program would be incurred by society with or without a new program. The question is, what should be the balance between the public and private sector? What should be the balance between people having to dig into their own pockets and spreading the cost more broadly over society?

We estimate that the near-term, that is 1988, public cost of a fully implemented public insurance program would be indeed expensive, between $38 and $47 billion, depending on program design. It has to be compared with the roughly $22 billion that all levels of government currently spend on long-term care. A total payroll tax of somewhere between 2.4 and 3.1 percent, half on employers and employees with no cap on taxable salaries, would be required to fund the program.

If we took the current public long-term care programs we are already committed to, Medicaid and a small part of Medicare, and finance that on a payroll tax basis, it would require a 1.6-percent payroll tax.

The incremental tax can and should be reduced by a variety of other taxes, including estate or inheritance taxes, income tax surcharges or excise taxes; through premiums paid by the elderly; and some State financial responsibility for long-term care.

In conclusion, the development of the market by the private sector with encouragement from the government could make long-term care much more affordable for a substantial fraction of the population. However, even with maximum development of private options, public spending for long-term care, mostly under Medicaid, will increase rapidly for the foreseeable future.

Since continuing to rely on a welfare program to finance long-term care for a large part of the population is undesirable, ways should be found to broaden Medicare coverage to provide long-term care, while again *leaving a substantial role for the private sector.*

Thank you.

[The statement of Mr. Wiener follows:]

CARING FOR THE DISABLED ELDERLY: WHO WILL PAY?*

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* These opinions are those of the author and should not be attributed to other staff members, officers, or Trustees of the Brookings Institution.

Testimony presented at a hearing on long-term care, Subcommittee on Health, Ways and Means Committee, U.S. House of Representatives, Washington, D.C., August 4, 1988.

It is time for Americans to face a serious problem--how to organize and pay for long-term care for the disabled elderly. More and more Americans are living past 75, 85, and even 95. Consequently, many more elderly than ever before suffer not only acute illness requiring hospitalization and a doctor's care, but also chronic disabling conditions that require long-term care either at home or in a nursing home.

Alzheimer's disease, osteoporosis, heart disease and stroke predominate among the many diseases that cause chronic disability among the elderly. These conditions bring both physical and emotional pain as people experience and relatives watch a decline in the ability to do things that most of us take for granted. Long-term care is the help needed to cope, and sometimes to survive, when physical or mental disabilities impair the capacity to perform the basic activity of every day life, such as eating, toileting, bathing, dressing and moving about.

The United States does not have, either in the private or the public sectors, satisfactory mechanisms for helping people anticipate and pay for long-term care. The disabled elderly and their families find, often to their surprise, that neither private insurance nor Medicare covers the costs of long-term care to any significant extent. The disabled elderly must rely on their own resources or, when these have been exhausted, turn to welfare. The aging of the baby boom generation combined with rapidly falling mortality rates for the elderly will lead to sharply increased demand for long-term care that will require substantially greater public and private spending far into the next century. Before additional stress is put on this inadequate system, Americans should carefully consider alternative ways of financing long-term care and what role the federal government might play in them.

How Do We Pay for Long-Term Care Now?

Most elderly people are not disabled. Of the 28.6 million Americans aged 65 and over in 1985, less than a quarter (6.3 million) were disabled. But the incidence of disability is high for the very elderly. Only about 13 percent of people aged 65-74 were disabled in 1985, but that proportion rises to 58 percent for people aged 85 and over. Mortality rates at advanced ages have come down dramatically in recent years, bringing increases in the number of disabled elderly.

Most disabled elderly are cared for at home, which is where they greatly prefer to be. Caregivers are usually relatives--generally spouses, daughters, or daughters-in-law--and occasionally friends. This unpaid care which frequently put great strain on families, is sometimes supplemented by paid services, such as home health workers, homemaking help, or by adult day care and respite care. Only about 21 percent of the disabled elderly were in nursing homes in 1985.

Most families who seek nursing home care find it beyond their financial reach. The cost of a year in a nursing home averages about $22,000 and can be much higher. Although families are the predominant provider of long-term care in the United States, nursing homes dominate long-term care financing.

Only a trivial portion of total long-term care bills are now covered by any form of insurance--public or private. The disabled elderly who pay for long-term care do so out of their own or their family's income and assets. They turn to Medicaid, which accounts for 71 percent of government spending on long-term care, if they are poor or have "spent down" their income and assets to levels that make them eligible. Out-of-pocket spending amounts to a little more than half, and Medicaid for a little less than half, of all expenditures for nursing-home care.

The dominance of private out-of-pocket spending and Medicaid in long-term care finance creates a two-class system of care. Medicaid reimbursement rates are below rates charged private-pay patients. As a result, Medicaid patients tend to receive lower-quality care and often find an inadequate supply of services and waiting lists for admission. The fact that Medicaid normally covers nursing home care, but little home care introduces an institutional bias into the system. Financing long-term care through Medicaid is perceived as demeaning by beneficiaries, especially middle class beneficiaries who never expected to be on welfare, as inadequate by providers, and as expensive by state and federal taxpayers.

Although the United States has a highly developed private insurance industry and broad social insurance coverage, especially for the elderly, little attention has been paid to ways of financing long-term care. The development of insurance approaches has been inhibited most likely by uncertainty arising out of two characteristics of long-term care:

- Because long-term care is needed primarily by the very elderly, a long time is likely to elapse between the time provision for financing might be made and its use. Possible changes in mortality rates, income, inflation, use of services and the risk of disability over this period creates major uncertainties both for buyers and sellers of long-term care financing.

- Long-term care is currently provided primarily by relatives. Once financing is available, there is considerable risk of "moral hazard" (greater use of paid care once financing is available), especially for home care.

Whatever the reasons, the United States so far has relied for long-term care financing on a patchwork of private out-of-pocket spending and a means-tested welfare program. Pressure on this patchwork system will mount as the population of disabled elderly increases.

Increasing Strains on the System

Over the next several decades, the bill for long-term care is certain to use rapidly. Using the Brookings-ICF Long-Term Care Financing Model, we have made detailed projections of the disabled elderly population to the year 2020, together with their income, resources and likely use of long-term care, assuming that mortality rates continue to decline, incomes and inflation continue to grow at moderate levels and current policies with respect to financing long-term care do not change. Over the next three decades, they show:

First, the number of older people will grow rapidly and the number of very elderly will rise even faster. Because they will be older, more of the population over 65 will be disabled. The increase in disabled elderly will mean more users of long-term care, especially nursing home care. While the number of people over 65 is projected to increase 61 percent over the period, the nursing home population will increase 76 percent. Nursing home residents will also be older--51 percent of them will be over 85 in 2018, compared with 42 percent in 1988.

Second, older people will be significantly better off financially by 2018, but the income and assets of the younger elderly will increase much more rapidly than those of the very old. Real incomes of people aged 65-74 will more than double over the three decades due to more and higher pensions, increases in Social Security benefits and income from assets. Incomes of the 85 and over group, who are most likely to be users of nursing homes and home care, will go up only about 17 percent in real terms. This group is already in their fifties and will not benefit as much as younger cohorts from expected increases in pension availability and labor force participation by women.

Third, long-term care spending will increase rapidly, especially for nursing homes. If nursing home costs rise 5.8 percent per year (compared with a 4.0 percent increase assumed for the general price level), nursing home spending for the elderly will more than triple, rising from $33 billion in 1988 to $98 billion (in constant 1987 dollars) by 2018.

Medicaid spending will rise faster than total long-term care spending and the proportion of nursing-home patients dependent on Medicaid will not decline. This last result is surprising. Since the overall economic well-being of the elderly is expected to improve substantially over the period, why should they not become less dependent on a program intended for the poor? The answer is that long-term care costs are projected to rise faster than the incomes of the very elderly, the group most likely to use long-term care. Thus those with the greatest risk of needing care will actually be worse off in the future in terms of their ability to pay for it.

Finally, although the number of disabled elderly likely to use long-term care will increase dramatically, the economy will grow as well. The financial burden of long-term care will largely depend on how fast the economy grows. Under a low growth assumption (1 percent real growth a year), total long-term care expenditures increase from 0.89 percent of GNP in 1988 to 1.92 percent in 2018 (and 4.22 percent in 2048). In contrast, under a high growth assumption (3 percent real growth a year), total long-term care expenditures will only grow to 1.05 percent of GNP in 2018 (1.28 percent in 2048). While long-term care will clearly be an additional burden on the economy, moderate levels of economic growth should lessen that stress.

Options for the Future: The Private Sector

There are a wide variety of alternative ways that long-term care might be financed in the future. We focused first on several widely discussed private sector initiatives including:

- increasing incentives for private saving by creating individual medical accounts (IMAs), savings accounts earmarked for long-term care that would receive favorable tax treatment by the federal government;
- increasing the ability of older people to use the equity accumulated in their home (normally their principal asset) to pay for long-term care through home equity conversions (HECs);
- pooling the risk of high long-term care expenses through private long-term care insurance;
- establishment of continuing care retirement communities (CCRCs) or residential complexes with independent living units for older people and a guaranteed availability of care (from occasional home care to full nursing home care if needed) for the life-time of residents;
- formation of social/health maintenance organizations (S/HMOs), an extension of the health maintenance organization concept of prepaid health care financing to include long-term care services.

In projecting the potential market for private sector initiatives for the next three decades we made optimistic assumptions about the number of people who would participate in private sector financing. Our purpose was to determine the most that can reasonably be expected from the private sector with respect to participation, proportion of long-term care expenses financed, and reduction in the use of Medicaid.

Our projections indicate substantial potential for growth of private sector financing mechanisms for long-term care. A potential multibillion dollar market is almost entirely untapped. People purchasing these products will have better financial protection.

Even under our optimistic assumptions about who would participate, however, private sector financing cannot be relied on to do the whole job. Private sector approaches are unlikely to be affordable by a majority of elderly, to finance more than a modest proportion of total nursing home and home care expenditures or to have more than a small impact on Medicaid expenditures and the number of people who spend down to Medicaid financial eligibility levels. For example, we estimate that by 2018, private long-term care insurance sold to those aged 65 and older may be affordable by 25-45 percent of the elderly, may account for 7-12 percent of total nursing home expenditures and may reduce Medicaid expenditures and the number of Medicaid nursing home patients by 1-5 percent. Those general conclusions also apply to individual medical accounts, continuing care retirement communities, and social/health maintenance organizations. Home equity conversions and private insurance sold to people under age 65 are only the options in which a substantial majority of the elderly might participate. However, home equity conversions have limited potential for paying large long-term care bills directly, and thirty years from now, private insurance sold to people under age 65 might pay for only 17 percent of nursing home expenditures.

Private sector options have a limited impact because they are so expensive that most elderly cannot afford them. Since total long-term care expenditures per capita age 65 and over exceed $1,300 a year, this is hardly surprising. Total (public and private) long-term care costs roughly equal Medicare Part B expenditures and exceed three-fourths of Medicare Part A expenditures. Thus, costs never become trivial even when spread over the whole elderly population.

Although private long-term care insurance policies are rapidly evolving, policies now available are also limited in the amount of financial protection that they offer. For example, policies often have prior hospitalization requirements, pre-existing condition exclusions, age restrictions on who may purchase policies, and limits on the levels of nursing home care covered. Very little home care is covered. Reimbursement levels usually do not increase with inflation, which can be a serious problems because a payment level that is adequate today will not be adequate in the future. An indemnity policy with a $50 per day nursing home benefit purchased at age 65 when its relatively affordable needs to pay over $150 per day at age 85 to have comparable purchasing power. The problem is that improved coverage and affordability are tradeoffs. That is, coverage improvements are likely to make products more expensive, thus reducing affordability. For example, indexing the indemnity level to inflation would probably increase premiums for the elderly by about 30-40 percent.

Options for the Future: The Public Sector

While it is desirable for the private sector to play a much greater role in financing long-term care, our projections indicate that it is not reasonable to count on private initiatives to reduce substantially Medicaid spending for long-term care or to decrease appreciably the number of lower- and middle-income people spending-down to Medicaid eligibility. The question then is: should the nation stick with a means-tested welfare public program as its major program for financing long-term care or should it enact a new program of social insurance?

The principal argument for staying with a means tested approach is that Medicaid, despite its many deficiencies, does meet the most urgent needs of the low-income disabled elderly population at minimal cost to the taxpayer. The spend-down requirements ensure that Medicaid finances only that part of the care that is beyond the resources of the elderly. While targeted on the poor, Medicaid also provides a safety net for middle-income people with high long-term care expenses.

Making the Medicaid means test less onerous and reimbursement rates more adequate would make life better for the elderly, but would retain the fundamental welfare character of the program. Desirable changes include increasing the personal needs allowance and the level of protected assets for patients and raising the amount a Medicaid patient's spouse is allowed to retain for living expenses.

Although incremental improvements in Medicaid are attractive and not inconsistent with more fundamental restructuring of the public role in financing long-term care, public charity always carries some stigma, and efforts to reduce taxpayer costs are likely to perpetuate a two-class system with inferior care and status for Medicaid patients. Moreover, it is an odd welfare program whose eligibility requirements are met by a majority of the people using services. In other U.S. welfare programs, such as Aid to Families with Dependent Children and the Supplemental Security Income program, only a small minority of the population is expected to be financially eligible.

It would be greatly preferable to recognize that long-term care is a normal, insurable risk for the elderly, which should be covered under a general social insurance program like Medicare and not through a welfare program like Medicaid. Everyone should contribute to public long-term care insurance and earn the right to benefits when they need them without having to prove impoverishment. Social insurance coverage, however, should not make long-term care free, or even nearly free to Medicare beneficiaries. Substantial cost-sharing is appropriate to control increases in service use that might occur if financing were newly available to the large number of disabled elderly who do not now receive paid care. Indeed, with respect to home care, where the risk of increased service use is far greater than for nursing home care, limitation of benefits to the severely disabled, strictly defined, would also be desirable.

Public costs and the taxes necessary to pay for a public insurance program would be substantial, but need not be unmanageable. Moreover, most of the costs of a public insurance program would be incurred by society with or without a new program. We estimate that the near-term (1988) public costs of a fully implemented public insurance program would vary from $38 billion to $47 billion depending on program design, compared with $22 billion under current policies.

A payroll tax of between 2.4 and 3.1 percent, half on employers and half on employees with no cap on taxable salaries, would be required to finance the program. If current public long-term care programs were financed by a payroll tax, the cost would amount to 1.6 percent of payroll. The incremental tax can, and should be reduced through estate or inheritance taxes, income tax surcharges, or excise taxes; through premiums paid by the elderly, and by retaining some state financial responsibility for long-term care.

Conclusion

Major new initiatives are needed both in the private sector and in the public sector to improve the financing of long-term care. Americans should recognize that long-term care is a normal risk of growing old that needs to be anticipated. A large potential market exists for private long-term care insurance and other private initiatives. Development of that market by the private sector with encouragement from the government could make long-term care much more affordable for a substantial fraction of the population. However, even with maximum likely development of private options, public spending for long-term care, mostly under Medicaid, will increase rapidly for the foreseeable future. Since continuing to rely on a welfare program to finance long-term care for a large part of the population is undesirable, ways should be found to broaden Medicare coverage to include long-term care.

Although financing long-term care has traditionally been viewed as an insolvable problem, it is actually one of the more tractable social issues facing the United States. Indeed, unlike crime, poverty, racism and teenage pregnancy, financing long-term care has a range of known and feasible solutions. The question is whether we as a society have enough political will and ingenuity to choose among them and put an improved system in place.

Chairman STARK. Thank you.

You prefer to see Medicare as the program providing for long-term care, and I gather that you would make all seniors eligible for this benefit?

Mr. WIENER. That is correct.

Chairman STARK. And that you would include nursing home care because of more complications and more difficulty in determining the need for home health care?

Mr. WIENER. No, not exactly. Ideally, you would want to cover both home care and nursing home care. I think long-term care is a two-legged animal, and you really need both. A lot of people need home care who are not receiving it. There are also a lot of people who incur very major catastrophic costs by going into nursing homes.

Chairman STARK. Are there other benefits?

Mr. WIENER. I think my definition of home care is rather broad, and would include homemaker services, personal care, adult day care.

Chairman STARK. I guess I am leading to the kind of social HMO type model of, if that can be considered the nature of preventive——

Mr. WIENER. I think social HMO's are a good idea, and I would encourage the development of them. I think one of the great attractions of social HMO's is that they bring together the long-term care sector and the acute care sector, and taking from acute care to give to long-term care so that the incremental costs of premiums would be reduced.

I think that is an excellent idea. The demonstrations we currently have in place have had reasonable success, but they have had difficulty getting people to enroll. The overall constraint on social HMO's is that it has to be some subset of the number of people who enroll in health maintenance organizations, and that will remain a minority, especially among the elderly.

Chairman STARK. I assume that you would concur that we need some kind of cost-sharing deductibles?

Mr. WIENER. Yes, I am a very strong advocate of that, especially on the home care side.

Chairman STARK. Tell me how you would suggest—there is a problem. We could start tomorrow with a full-fledged program. Let's just say we take the high end of it, your $50 billion program.

Obviously, if we start tomorrow with full benefits, we are not going to have a chance for all the people 65 to 90 to start saving in their fifties. They can't go back, they are out of the loop. So, we have a phase-in program, where it will get more costly until people are going to either pay extra taxes or until we build some reserves or they build some resources for this, so how best ought we to conserve?

I mean, do we phase in with deductibles or is it so important that we swallow the whole lump and just say that this is what the general taxpayers pay to get the program started?

Mr. WIENER. Well, that is a difficult question to answer, and I don't have views that are set in concrete on that. I think, on the nursing home side, you could start either with Senator Mitchell's approach, which covers the back end, or the approach that Bob

Ball has proposed and is embodied in the Kennedy bill, of starting at the front end, covering 6 months of nursing home care. I don't think the whole elephant can be swallowed at once. It is going to have to be phased in.

I think you do make one particular point that is important in the long-term care area, and that is that the elderly who are retired today will be with us for a long time. Those that are age 65 now won't be using long-term care probably for another 20 years. Thus, all of the employer-based that some of the insurance companies are now talking about are basically not feasible for them.

Chairman **Stark**. Here is a problem that I anticipate, and I wonder if you share this. In my district, there are just an awful lot of seniors, and throughout the country there are an awful lot of seniors whose incomes are in the neighborhood of $10,000 or $12,000 a year. Now, many of them may own their own homes free and clear, which takes some of their housing costs out, but nonetheless, it is a pretty low income for a person to survive on in today's economy.

Is the attractiveness of a nursing home with 21 meals a week, a color television in the club room, and clean sheets once a week, and some cleaning care and assistance, so attractive that we will just have this tremendous rush for people to attempt to basically use any program for nursing home care really as an income supplement?

I mean, it would make sense to me that if you can't afford it, if you run out of money at the end of the month and can't afford decent meals, that you may look at the local nursing home as a comfortable place to live.

Mr. **Wiener**. I guess I don't agree. All of the research that has been done has found that the elderly want to stay out of nursing homes. In the 1982 National Long-Term Care Survey, 95 percent of the disabled elderly who were surveyed said it was extremely important to stay out of a nursing home as long as possible.

While you do get 21 squares a week, you also have to share a room. I am not sure I would want to share a room with someone I had never met before after spending my entire life living in my own house. So I don't think there is a danger that nursing home use will explode.

On the other hand, I think there is no doubt whatsoever that nursing home use would increase under either public or private insurance. Conventional economic theory tells us that people buy more of a good when it costs less, and the primary thing that insurance does is to reduce the out-of-pocket cost of nursing home care and home care.

So, I think we definitely need to build that into our cost estimates. I think the possibility for increased use is more on the home care side than it is on the nursing home side, but I think we have to be prepared for it on both sides.

Chairman **Stark**. One final question. What role do you see for Medicaid if we were to follow your suggestions and basically take this all as a Medicare——

Mr. **Wiener**. I think there always will be a role for Medicaid. There will always be people who will be poor and will not be able to afford whatever level of cost-sharing we set. I think the goal should be to try to minimize the number of people who have to depend on it, but I think it is a mistake to think that Medicaid will totally fade away. It is important that when we think about doing things on the social insurance side, that we also be thinking about improvements in the Medicaid program for those people who are left on it.

High on my own personal list would be raising the personal needs allowance and raising the level of protected assets.

Chairman **Stark**. Do you think that including that service in the Medicare program would do a disservice, it would politically cloud up Medicare? One way to do that is to say, we will do this. We have covered all but about $2,500 under Medicare now, and with the balance purchased by Medicaid if the people are very poor, we get into a little State-Federal fight, States having different qualification levels.

Might it be a better idea to say Medicaid is out of the seniors business and have these two programs provide for indigents as well as those who can afford the insurance portion?

Mr. **Wiener**. Certainly a viable option is to take the long-term care portion out even for the Medicaid part of it, and put that in a Medicare program. That is certainly something worth considering.

Chairman **Stark**. Thank you.

Mr. **Gradison**. Thank you, Mr. Chairman.

Some of the elderly have sufficient income or assets to be able to handle the risks of home health care?

Mr. **Wiener**. There are certainly some. But at $22,000 or $25,000 a year, it is hard to manage for very long out of pocket. Many more people could afford insurance. But if you look at the income and assets of the population at primary risk of nursing home care, the 85 and older population, 56 percent of those have incomes under $7,500. About 75 percent of those report less than $10,000 in nonhousing assets. So, when you get up to the 75 and older population, you are talking about a group that is not doing that well financially.

Mr. **Gradison**. How about 10 or 20 years from now, how would you account for people who have benefited from the inflation of home values in recent years?

Mr. **Wiener**. Our projections show that the income of the elderly over the next several years will increase substantially, but the bulk of that increase in assets will be for the relatively young elderly. Our projections are that over the next 30 years, the income of the 85 and older population will increase only by about 17 percent, while the income of the 65 to 74 year olds will approximately double.

Mr. **Gradison**. What is the social purpose of providing a mandatory government program that covers those few who are able or willing to accept this risk, financial risk themselves?

Mr. **Wiener**. I think it is the same one we have for Social Security and Medicare, and that is that we have a situation where the overwhelming majority of people can't handle this on their own without financial hardship and so what we try to do is pool the risks across a very broad population. We also use the tax system to redistribute some of the cost so that upper income people pay somewhat more of the cost than lower income people.

Mr. **Gradison**. Would you comment in general about, with regard to your thoughts about financing the program you have recommended along the lines of our catastrophic health insurance financing? Your plan basically, as I understand it, asks the nonelderly and their employers to pay the cost of long-term care benefits for the elderly.

In fact, as I understand your plan doesn't extend long-term care benefits to anyone but the elderly, so there is definitely a tax on one age group to support the other. Have you investigated the possibility of applying the principles that were embodied in the legislation the Congress recently passed to the financing of this new type of care for the elderly?

Mr. **Wiener**. First of all, we don't have a plan, per se.

Mr. **Gradison**. You do have in there a big increase of new social insurance tax, payroll tax matched by employers comparable to Social Security. Is that not your recommendation?

Mr. **Wiener**. That is correct. But we don't have a plan, per se. We endorse the general principle. The study that we did, looked at the elderly, we don't address the nonelderly. But I have no doubt in my mind that, both for matters of equity and political reality, the elderly must pay a substantial part of any cost of any new program.

I think it is a complete nonstarter to say that the elderly will not pay a substantial part of this kind of program. I think the question is how much, and I don't have a fixed sense of that, but they clearly have to pay a substantial part of it. But I think one of the lessons from catastrophic is that if you are going to put the burden totally on the elderly, there will be a limit on how much you can do.

Mr. **Gradison**. I am not really suggesting we do that, but I am suggesting that there are political hazards in asking middle and lower income workers to pay an additional payroll tax, which in the minds of some is a method of preserving assets in the estates of upper income elderly. I think that is a real political problem.

Mr. **Wiener**. I would agree. While the figures I gave are for financing it totally through the payroll tax, those are for illustrative purposes only. I would very strongly support estate taxes and income tax surcharges. We must make sure that upper income people pay more than their fair share of the cost of this program. I absolutely agree with you that we do not want to wake up one day and have a program where the net effect is to redistribute finances to wealthier people.

Mr. **Gradison**. Under Medicaid? The lowest income elderly, depending on where they live of course, but the lowest income elderly are protected, so isn't this whole issue a question of what the appropriate government role is in providing long-term care for the nonpoor elderly?

Mr. **Wiener**. The problem is that it is not just the poor elderly who end up on Medicaid. We have a situation where the majority of people who end up in nursing homes end up on Medicaid. Many of those people have worked their whole lives, were independent, but in their waning hours of life ended up having to go to that welfare office and apply for Medicaid.

And to me, whenever you get a situation where a large majority of people end up on welfare, that is probably not an appropriate way to finance the system, because it means that a majority of people are not able to finance it out of their own income and assets, that we need some broader mechanism to protect people.

Mr. GRADISON. Thank you. I appreciate your help.

Thank you, Mr. Chairman.

Chairman STARK. Mr. Coyne.

Mr. COYNE. Thank you, Mr. Chairman.

Doctor, approximately 82 percent of all noninstitutionalized dependent elderly have relatives that care for them. What provisions or options might be available to those who are alone? Have you studied that problem?

Mr. WIENER. Well, I think there is a range of paid home care services that can be used to try to keep people at home. They include homemakers, home health, adult day care. There is a range of those kinds of services. You are right that the bulk of care that the disabled elderly receive in this country is informal care, unpaid, by family and friends.

Mr. COYNE. Are there any plans offered by nursing homes that would expand services to include home health care?

Mr. WIENER. I couldn't name a particular one, but there are a number of nursing homes that are looking beyond their institutional walls to the provision of home care.

Mr. COYNE. Thank you.

Chairman STARK. Mr. Moody.

Mr. MOODY. Thank you.

I am sorry I was not here for most of your prepared statement. We were voting, as you may know, but I appreciate the time and thought you put into this. To what extent do you think such a program should be generationally neutral in the sense that each generation pays the freight for its own long-term care as opposed to transfers through the payroll tax or in other ways?

Mr. WIENER. I think it should be as generationally neutral as possible, but I think it is inevitable that there be some transfers in setting up this kind of program.

Mr. MOODY. I mean, aside from the introductory phases.

Mr. WIENER. That will be with us for a long time. It is not a two or 3-year problem, it is probably a 10- or 20-year problem, because that 65-year-old will not be using long-term care for another 20 years.

So, I am in favor of trying to build up trust funds with reserves so that the current generation can finance its own long-term care services for the future.

Mr. MOODY. Since it is a fairly statistically predictable risk, why isn't this simply an insurance problem? And I gather that is the brunt of your statement, that it should be treated as an insurance problem, like Social Security and not as a welfare problem like Medicaid.

Mr. WIENER. I agree that it isn't an insurance problem while I reviewed a wide variety of options, I think what we really come down to is public insurance and private insurance. What we have is a situation where for individuals the cost is catastrophic, but if you can spread it over a very wide population, the costs become more manageable.

Mr. MOODY. I couldn't hear you.

Mr. WIENER. The costs become more manageable.

Mr. MOODY. But it is a mandatory risk pooling?

Mr. WIENER. Yes.

Mr. MOODY. If it is so predictable, why don't we let private insurance handle it? There is a small variance, I assume?

Mr. WIENER. It is not so clear. Clearly, one of the barriers for private insurance has been that there has not been a whole lot of data available about nursing home care and home care use. I think that is improving, and will improve dramatically over the next several years, but I think there are problems both on the demand side and on the supply side in terms of the provision by the private sector or private insurance.

On the supply side, insurers have worried about whether long-term care is an insurable risk. They have worried about the increased use or moral hazard if they offer insurance. They worry about adverse selection, that the people who buy the insurance know that they are going to be the ones who are going to use long-term care.

Mr. MOODY. Why would that be a problem if people avoid institutional long-term care? I am talking about institutional care.

Mr. WIENER. Well, I think——

Mr. MOODY. I am looking for market failures.

Mr. WIENER. The market failures are that the insurance companies have worried, they continue to worry about moral hazard. You and I can discuss that we don't think it will be so great, but they are the ones who are going to be taking the financial risk. They worry a great deal about it, and I think it is exacerbated by the fact if they sell to someone age 65 that person isn't likely to use long-term care for another 20 years. Over 20 years, a lot can happen to mortality rates, a lot can happen to disability rates and to nursing home use rates, to nursing home inflation, and that is just a whole lot of risk.

And so, they have been very nervous. So they have not gone into it with great speed so far. They are edging into it. The number of companies offering policies is increasing rapidly. The number of policies is increasing, but we are at a situation where we have maybe 400,000 to 500,000 policies—2 percent of the elderly. In order to control their risk, most of the policies have a lot of restrictions which reduce the level of financial protection that they offer.

On the demand side, we also have a situation where, while it is again changing, historically the elderly have been disproportionately poor, and those things that require substantial out-of-pocket payments by the elderly were not possible.

We had a lot of misunderstandings about what their coverage was under Medicare and medigap. They thought they had long-term care insurance, and it was called Medicare. That is improving. I think there has also been, up until recently, a great unwillingness to accept the risk that needing long-term care for a long period of time was a normal risk of growing old. People were willing to consider the fact that, yes, they were going to get sick and they needed to see the doctor, might have to go to the hospital, but relatively few people have been willing to accept the fact that they face a significant risk of becoming disabled, unable to eat, to bathe, to dress themselves, and that they may need a substantial period of time of nursing care or home care.

Mr. Moody. Do you think people are unaware of their own risk in this case? Unwilling to face it?

Mr. Wiener. I think psychologically that has been part of the problem. Even within the academic community there has been an underestimate of what the lifetime risk of entering a nursing home is. According to our estimates, lifetime risk of entering a nursing home for some period by a person attaining age 65 is somewhere between 35 and 50 percent.

Mr. Moody. So, the basic market failure is information? Both on the demand side and the supply side? We don't have the data on the supply side, and people either psychologically or otherwise are not prepared to absorb the information on the other side.

Mr. Wiener. Yes, it is uncertain on the supply side. I don't know if I would call it——

Mr. Moody. There is not enough history.

Mr. Wiener. Right. There is not a long period of time where insurers can say, yes, we offered insurance and——

Mr. Moody. The numbers haven't stabilized because we don't have the numbers to test it out.

Mr. Wiener. And so long as you stay within the elderly population, the costs of these products are rather large. Total per capita of long-term care costs are about $1300 for elderly. Total aggregate long-term care costs are roughly equal to Medicare part B expenditures, and roughly equal to three-quarter of part A expenditures, so when you spread them over the whole elderly population, the costs stay fairly high.

Mr. Moody. I guess a concern I would have is if we decide we have to have a public response to this problem, and I tend to support it, that we will never have a chance to do it. The public will crowd out the private, and by the time enough data is available, there will be no institutional room to do it.

Mr. Wiener. Well, I guess I wouldn't agree with you. I don't think it is likely that the Government will swallow the whole elephant, and that will leave a substantial role for the private sector. There are at least three different ways that are currently being discussed that the private sector could fill that role within the context of an insurance program.

In the bill proposed by Senator Kennedy, public nursing home coverage would really only be for 6 months, maybe the first year, leaving the private insurance the years remaining. In Senator Mitchell's bill, there would be a 2-year deductible period, and if people want any protection of a serious sort, they would have to buy private insurance for that 2-year deductible period. Even under a more comprehensive program, there would surely be deductibles and coinsurance. I think the Medigap market shows that insurers could fill in there as well.

Mr. Moody. So, not on this front-ended gap or rear-ended gap——

Mr. Wiener. That would be a third potential market.

Mr. MOODY. This copayment feature, if it is built in, would tend to minimize the supply-side information risks that you referred to earlier? You mentioned all the things that could happen, nursing home, cost inflation, the more you build into payments, the more that becomes an insurable risk?

Mr. WIENER. That is certainly the purpose of having it.

Mr. MOODY. Okay. Thank you.

Chairman STARK. Mr. Daub.

Mr. DAUB. How are you doing, Josh? Nice to see you.

Mr. WIENER. Nice to see you.

Mr. DAUB. I guess Mr. Moody touched on the one point I dwell upon the most, which is, in our rush to do something about a perceived problem with the growing numbers of elderly, we will not give the private markets a variety of sources, including social structures in cities and communities, a chance to figure out options as well.

And if we socialize the program, if we federalize the program, if it is too extensive, we arguably do some smoke-and-mirror language in the statute that would arguably offer the prospect of a cost limitation of some kind that over time, it simply wouldn't work.

For example, the Kennedy idea, you let the private sector take up every year after the first year, how long do you think it will be before the Government will extend it to the second and third year? You remember Kerr-Mills, don't you? It was quite a key and unlocked the door to have a private sector ability for workplace incentive retirement programs, if you remember.

We don't include health care for that tax inducement. In fact, if you provide an after-workplace health-related retirement benefit, it is not tax-deductible. That is, the trip to Sunset City is deductible, but the trip to the hospital is not, if it is workplace paid for for after-work retirement use. That is the kind of thing I think we would preclude.

Mr. Moody, if we legislate too quickly, a comprehensive—what we might in the short term argue is a comprehensive health care solution for the nursing home care or home health care costs you are talking about. So I am not sure we have the right definition yet for long-term health care, do you?

Mr. WIENER. The question you are basically asking is, do I know the future with great certainty as to what the private sector can do, and the answer is obviously, I don't. What I can say is that I spent most of the last three years trying to project 30 years into the future what the role of private sector financing mechanisms might be.

And in doing those simulations, we made what I consider fairly optimistic assumptions about the willingness of people to dig into their own pockets and pay the premiums and the willingness of insurers to get beyond their fears about moral hazard, adverse selection and to aggressively market policies.

Thirty years into the future, we found substantial growth for the private sector, but across none of the options that we looked at did we find the way in which we finance long-term care revolutionized.

In none of the options did we find that social HMO's or individual medical accounts would pay for 25, 35, 45, or 60 percent of long-term care expenditures. They were all down in the teens. So, I guess my view is that the private sector can do a whole lot more than it is doing now.

But we just didn't find any evidence to suggest that they would be able to carry the bulk of the problem and that they would be able to revolutionize the way we finance long-term care or that they would make drastic reductions in the use of Medicaid services and Medicaid expenditures.

Mr. DAUB. But there wasn't any evidence that 80 percent of all Americans would have a medigap insurance policy when we first started to think about the potential of private sector markets. There wasn't any thought that 60 or 70 percent of Americans reaching age 65 would have some kind of a pension but for the tax incentives that we put in, and then we let the system develop.

I mean, the only point I want to make is that today's evidence, I would agree with you, wouldn't give you much hope that more than 20 or 25 percent of the long-term care could be shouldered by the private sector, but I think it is short-changing the potential of the private sector to say that that is as much as we are ever going to expect individuals or businesses to be able to do what I think Congress might want to do, is figure out tax incentives that over a 30-year period might give the same kind of long-term care benefit that now most Americans can get through the Tax Code, through the workplace for their general retirement.

And I think on that basis, we could see at least 50 percent of the costs we now anticipate would be federalized or shifted for long-term health care costs through the Federal Government, not to be a tax expenditure, and that would leave, in my judgment, a good deal more for the Federal Government to use for those who truly need it.

So, I guess I am getting to the point that you reject means tests or income tests as one way of reaching our objective in the Brookings study?

Mr. WIENER. I think you asked two questions, one about means tests and the other about what I think employers can do.

Again, I think that we will have a Medicaid program and long-term care, whatever we do, and we ought to do our best to fix it up. But to me——

Mr. DAUB. Why do you think we will have it no matter what the logic dictates?

Mr. WIENER. Because we will always have poor people with us, and poor people will be unable to pay even modest co-insurance and deductibles.

Mr. DAUB. Maybe we do away with some of that kind of thinking and put it together in one program for those who have the poor part, and then maybe——

Mr. WIENER. Certainly, we will always have part of that.

Mr. DAUB. If they accept the means test idea, it is there; we just don't want to talk about it.

Mr. WIENER. No, I think we want to talk about it, and I have proposals to improve it. What I am saying is that the question is, do we want a means-tested program to be the principal way in which we finance our long-term care programs through the public purse. And to me, after having worked with Medicaid programs in

Massachusetts and New York, they inherently have a public stigma, and they just don't have the broad kind of political support that we would have through social insurance programs.

Now, in terms of what employers can do, I would support tax changes that would make it more attractive for employers to contribute to private and long-term care insurance policies. I think we need to look at the whole issue of retiree health benefits and try to fix that up.

But I think the more urgent public policy need is on the long-term care side and not on the acute care side. I think the public interest in having people obtaining insurance in addition to Medicare coverage is less than it is to get some employer-based private long-term care insurance.

But I think we have to keep in mind that employers already have a very large unfunded liability for retiree health benefits. They are not going to be looking for additional health benefits to be financing.

Moreover, the employers face exactly the same risks that insured face. If we are going to have people buy it at age 30, they will have 55 years of risk, where use of services can change, disability rates can change, inflation could change, all of that makes risky business. And insurers and employers are very worried about that kind of thing.

And so, what we have, I think, is a possibility of increasing private long-term care insurance through employers, and I think that should be strongly encouraged. But again, we need to keep in mind what we are likely to get at the end. Twenty years after Medicare went into effect, we have 25, maybe 30, percent of the elderly with some kind of employer-based retiree health benefit. I would expect that long-term care insurance would only be some subset of that number. I don't expect companies that aren't offering any retiree health benefits now to be offering long-term care insurance.

Mr. DAUB. My comment would be that it would depend upon what kind of incentive it was. It could be a stair step incentive, just as popular and useful to bargain for and obtain long-term benefit as it would be to have some other kind of thing from your company.

It just depends on what the inducement might be. It is a difficult subject for me to address, because I tend to find the logic of politics and the gray number of heads out there propelling the short-term solution, and the problem is preliminary numbers, it was implied in what you said, socially acceptable thing, the judgments you made in Massachusetts and New York, you didn't find them acceptable socially.

Well, what is acceptable socially might be whatever I can get that won't cost me anything. It doesn't mean that it is the right thing for the Federal central system to undertake. I would hope that whatever this committee, and I won't be a part of it next year, I think whatever the committee does, that it has symmetry to it. That there be a public sector-private sector balance, understanding, that what a lot of what we would like, we can't afford today, but the proper incentives may allow an improved picture over time.

Thank you, Mr. Chairman.

Chairman STARK. Mr. Donnelly.

Mr. **Donnelly**. Thank you.

I apologize for missing your prepared testimony, but I have had an opportunity to read it, and your advice and counsel is always welcome and appreciated by the subcommittee.

Let me just see if I get straight in my mind your position on income relation.

I thought you responded to a question by the chairman that you favor income-relating any expansion of the Medicare system to cover long-term care; is that correct?

Mr. **Wiener**. No, that is not correct. I said I think we need to have non-means-tested benefits through a general expansion of the Medicare program.

What we do need to do is to make sure that, one, the financing is very income-related and is progressive so that upper income people pay their fair share and more of the cost of the program and help subsidize lower and moderate-income people.

Second, we need to recognize that whatever we do on the social insurance side we will still have poor people with us. We will still need a Medicaid or Medicaid-like program and that that needs to be improved by making financial barriers somewhat less onerous.

Mr. **Donnelly**. So what you are saying is income relate to the taxpayer, but not the beneficiary?

Mr. **Wiener**. We coup the costs, make the income-related necessary on the financing side and not on the benefit side. So that the upper income person receiving the benefits will have paid or will pay a substantial amount of taxes to cover the actuarial costs of the benefits while they are working and otherwise.

Mr. **Donnelly**. While they are a beneficiary?

Mr. **Wiener**. I am in favor of upper income paying their fair share. I am very interested in making sure that we get the proper balance between lower income and upper income people. I think that is critical. I think we want to have——

Mr. **Donnelly**. Can you give me some specific suggestions on how we are going to finance this program?

Mr. **Wiener**. I think there are a couple of things.

First of all, if we are talking about a fairly broad program, we are going to need a fairly broad tax. You cannot nickel and dime a $25 billion program. Fairly broad-based taxes are payroll and income taxes. We are more used to paying for social insurance programs through a payroll tax, but we could do it through income tax as well.

Having done that, I think we want to try to make the incremental tax as low as we can by looking to other financing sources as well.

Mr. **Donnelly**. So you would favor either an increase of a payroll tax or an income tax or a combination of both?

Mr. **Wiener**. In combination with increased estate taxes, excise taxes, the elderly paying both coinsurance, deductibles and premiums, and maintaining some State financial responsibilities. I think the States should get some reduction in their financial burden, but we need to keep the States financially involved in paying for this kind of program.

Mr. **Donnelly**. What about income relating the deductible?

Mr. WIENER. I think that has a lot to recommend it in principle and not much to recommend it in practice.

It is very hard to do that without a fairly full-fledged look at an individual's income and assets and then it begins to have a very strong flavor of a means test.

So I think as from an equity perspective, income relating the benefit makes a lot of sense, but it just becomes administratively difficult to do and I think adds a level of welfare to the program that is undesirable.

I think perhaps the way to handle it is try to beef up the Medicaid program for lower income people and keep fairly high levels of copayment.

Mr. DONNELLY. Senator Mitchell recommends with regard to the estate tax that we put a 5 percent surcharge on estates over $600,000 and 5 percent flat tax on estates between $200,000 and $600,000.

What do you think of that?

Mr. WIENER. I am not an expert in the estate tax, but I think the principal of getting more money from estate tax is an absolutely right one. It is inevitable that one of the results of either private or public insurance programs would be to better protect peoples' assets.

Mr. DONNELLY. Do you agree with this statement: that the expansion of Medicare to provide long-term care will do two things; one, it will provide access to hopefully quality service and long-term care coverage; second, that it provides a guarantee that assets will be protected?

I say this because, under the present system, which is a bad system, you have to spend down your assets before you become eligible for any Government assistance whereas all of the proposals before this committee would stop that system and create a system where assets would be protected and you would still then be eligible for Government assistance.

Would you agree with any observations?

Mr. WIENER. My understanding of some of the proposals is that they would all have a net effect of protecting peoples' assets, but that proposals vary as to whether or not they do so explicitly.

Mr. DONNELLY. Well, in reality, they would because it would end the present system of spending down the assets.

Mr. WIENER. The practical effect would be to protect peoples' assets. It is important to remember that excluding the house, approximately two-thirds to three-quarters of the elderly age 75 and older have less than $10,000 in assets.

Mr. DONNELLY. But that won't be the case 20 years from now.

Mr. WIENER. They will certainly have more than they have now, yes.

Mr. DONNELLY. Let me ask you a question that I have been wrestling with for some time.

Where does the responsibility of the children lie?

Mr. WIENER. Well, I think——

Mr. DONNELLY. Or do we—the children have any responsibility for the care of our parents?

Mr. WIENER. Well, I think——

Mr. **Wiener**. I think children do have responsibility for their parents and by and large they have really bellied up to the bar and have really taken on an enormous responsibility and provided an enormous amount of care.

As was indicated earlier, about 80 percent of long-term care in this country is provided by family and friends. We have this mythology in this country that in the good old days people took care of mom and grandma, but now we dump them into nursing homes.

In the old days, people didn't live long enough for this to be a problem. We are getting to a situation where having a parent or grandparent who has a serious disability for a long time is becoming a normal life experience—an unpleasant one. People are providing the care and enormous quantities of it, millions of hours of informal care.

Mr. **Donnelly**. As we craft a program, how do we factor into the program the role that the children play presently and also what their responsibilities or rewards will be in this new program?

Mr. **Wiener**. I think that is a difficult question. I think you have to sort of strike a balance between providing the home care and the nursing home care that will provide some relief for those caregivers while at the same time not providing incentives for people to withdraw.

I think the evidence from the demonstrations that we have had which have expanded home care have suggested that contrary to the fears of many, caregivers have not withdrawn to any significant degree. They have used the home care services available as a supplement and not as a substitute.

Mr. **Donnelly**. It just seems to me there ought to be some incentive/reward for those children that are taking the responsibility of caring for their aged parents.

Mr. **Wiener**. There have been——

Mr. **Donnelly**. Versus those children that are not.

If we adopt the Mitchell approach, it would be a flat tax on the estate, 99.9 percent of the assets of the estates go to the children whether they care for their parents or not.

Maybe that ought to be the area where we provide that incentive or reward, through the changes in the estate tax.

Have you ever had an opportunity to look at that?

Mr. **Wiener**. Not from the estate tax perspective. We have looked more generally at tax deductions for people who care for disabled relatives.

We came to a conclusion that we had a tradeoff between equity and efficiency.

The equity argument is that people who are taking care of their disabled relatives should certainly not be worse off than people who don't.

On the other hand, we found very little evidence to suggest that we would get any behavioral change through some kind of——

Mr. **Donnelly**. It would not stimulate any behavioral changes, I am sure.

People have reasons for doing what they are doing, and changing the estate tax won't do that. But I do think that as the program is developed that we ought to pay some attention and give some emphasis to those individuals who are bearing the enormous responsibility today and provide not only incentives, but maybe a reward for that. For those who don't assume those responsibilities, that ought not to be rewarded. If anything, they should not benefit from an estate tax system that frankly I think presently is much too generous.

Mr. Chairman, having said that, I will yield back whatever time I have.

Thank you, Dr. Wiener.

Chairman **Stark**. Mr. Levin.

Mr. **Levin**. Let me change or somewhat change the subject, though I would like to make a couple of quick comments.

I think Mr. Moody's questions indicate that Democrats are willing to look openly at the issues of public-private mix and I just hope that is true on both sides of the aisle.

I think there is a tendency to rather reflexively choose up sides on this issue and I am not sure it is always helpful.

On income relating, I would hope that we would have similar fresh thinking.

In response to Mr. Donnelly's questions that I think also indicate a willingness on our part to look at this freshly, your comments come across this way, that you are in favor of income relating, but if you carry income relating very far in terms of equity, it becomes means testing.

I just think we need to look at this question of how much we want to relate benefits to income without labeling it too soon. For example, Mr. Mitchell's 5-percent tax isn't really a very serious infringement on the estates of high middle-income and high income families with lots and lots of assets.

They will take full nursing home and home care coverage in return for that 5-percent like this.

The question is whether they are paying their fair share of the freight.

I think that is what you are asking and I think we need to look at that.

But I want to shift a bit to talk about the interaction between nursing care and home care.

You, on page 11, say that a fully implemented public insurance program would vary from $38 to $47 million depending on the program design.

About how much of that would be home care payment, reimbursement, roughly? Is it a major ingredient?

Mr. **Wiener**. It is clearly a major ingredient, but I think one of the surprises that we had in doing our analysis is that the current system is so dominated by high-cost nursing home care that even if you expanded home care fairly substantially, it would remain a relatively small proportion of total long-term care expenditures.

I would be happy to supply that number for the record. It is in the book, but I just don't recall what it is offhand.

[The information follows:]

The near-term (1988) incremental public costs of a range of public insurance programs would be $16 to $25 billion. Of that amount, between $4 and $6 billion would be additional public spending for home care.

Mr. **Levin**. I think this issue is being driven much more by need than politics.

I think you are right about this dynamic change in demographics, but I don't quite know how you reconcile that with the statement earlier on page 11, indeed, with respect to home care—the word "risk" is there, potential you probably mean—of increased service use is far greater than for nursing home care, limitation of benefits to the severely disabled strictly defined would also be desirable.

How do you reconcile—what we seem to say is that the potential for home care is so large that it needs to be stringently confined, restricted in any public-private system.

Mr. **Wiener**. Well, I am in favor of largely expanding the home care role in the long-term care system and the public financing for it.

The fact of the matter is that most disabled elderly are in the community, not in nursing homes, and most that are in the community are not receiving formal home care.

That creates a potential risk of a substantial increase in use and I think that potential for substantial increase in use is one of the reasons, certainly not the only reason, that the Pepper bill went down to defeat.

Not only insurers, but Congress worries about the potential risk on what the costs are going to be.

If they knew exactly what the costs were going to be, they could decide whether it was high or low, but it is the uncertainty that adds another element to it.

So I think there are at least two ways to try to limit the uncertainty as to what those costs will be. One is to try to relatively strictly target to a fairly severely disabled group of people——

Mr. **Levin**. In the Pepper bill, when you use those terms——

Mr. **Wiener**. It is up to Congress to decide roughly how much it wants to spend and then you can craft an eligibility level that fits in.

In the book we used an eligibility level that is different and turns out to be not terribly different in numbers than what is in the Pepper bill. That ends up limiting the pool to a fairly seriously disabled population. Once you limited that population, the second way to try to limit the increase in use is to require people to have some out-of-pocket payment, to dig into their pockets to help pay for services.

I think one of the differences between home care and nursing home care is that there are a lot of services for home care that should be provided that have a degree of relatively inherent desirability.

People who can't prepare their meals need somebody to help prepare those meals. They need some homemaker services.

People who can't clean their houses need some way to help do that. That is something that is appropriate for severely disabled people, but it is also something that I would like to have done for myself.

I would be delighted if someone could take some of the housecleaning and food preparation burdens off myself and my wife. Therefore, to reduce the potential of increased demand, of trying to make sure it only goes to people who really need the service to get by, one of the ways is, in addition to case management, is limiting costs on a monthly basis.

Another way is to have some degree of cost-sharing. I think that is absolutely critical.

Mr. LEVIN. Thank you.

Your report surely has elevated the quality of discussion.

Thank you very much.

Chairman STARK. Mr. Gradison.

Mr. GRADISON. Mr. Chairman, I ask unanimous consent to include in the record of this hearing a statement with regard to H.R. 955 prepared by our Ways and Means Committee colleague, Congressman Crane of Illinois.

[The statement of Mr. Crane follows:]

PREPARED STATEMENT OF HON. PHILIP M. CRANE

Mr. Chairman, thank you for giving me the opportunity to discuss my views on long term health care. I am a cosponsor of H.R. 955, the Health Care Savings Account Act (HCSA), which has been introduced by Representatives French Slaughter and David Dreier. This bill would make it easier for individuals to pay for their post-retirement health care financing needs. Our legislation would also take pressure off of the Medicare trust funds—which could be bankrupt in 15 years, according to some estimates—by gradually allowing individuals to use their savings accounts to buy private insurance.

At the heart of this solution lies a savings plan similar to today's popular individual retirement account: the health care savings account. Individuals would be allowed to contribute an equal amount to their Medicare payroll tax each year. This payroll deduction, which funds Medicare's hospital insurance program, currently is 2.9 percent of salary up to $42,000, divided equally between the employer and the employee. Under our plan, employers could contribute to health care savings accounts in lieu of, or in conjunction with, their employees. The Medicare payroll tax would continue at its present rate, to finance current and future promised benefits, but 60 percent of the HCSA contribution could be taken as an income tax credit. Upon retirement, funds invested in a HCSA would continue to receive favorable tax treatment; withdrawals used to pay for health care—either directly or indirectly, through the purchase of private health insurance—would be excluded from taxation.

An individual contributing funds to a HCSA would have to pay an increased Medicare deductible based on the amount of health insurance he could buy with the savings accumulated in his HCSA. This calculation would be based on the portion of the HCSA funds that would be tax-credited; that is 60 percent of contributions. Our legislation would reduce or eliminate Medicare's long-term financing problems. The program's revenues would be maintained, while its future expenditures would be reduced substantially, as workers relied more on HCSA's and less on Medicare. In addition, retirees would have an incentive to restrict their use of medical resources, thereby conserving their assets in their HCSA's.

Workers who wished to continue to rely completely on Medicare would be free to do so. Current Medicare benefits would not be changed in any way, and individuals who did not choose to participate in the HCSA program would enjoy improved financial prospects for the Medicare system. But those who exercised the HCSA option would come out way ahead because they would receive higher retirement incomes. Benefits available through this combined HCSA—Medicare system would be far better suited to the needs of the elderly than current Medicare benefits.

In conclusion, HCSA's would offer new resources for long-term nursing-home care—an increasingly important need that presently is not being met—by inducing insurers to bear the start-up costs and the financial risks of aggressively marketing long-term care insurance nationwide. I hope that my colleagues on the Committee on Ways and Means will consider including this approach in the Committee's eventual long term care legislation.

Mr. DAUB. May I have inserted in the record remarks I would have delivered yesterday and the bill H.R. 3900 originally cosponsored by Mr. Donnelly and myself to commend it to the attention of the committee as those who are not here will pour over the record and read carefully a well-crafted bill.

Chairman **Stark**. Without objection, the bill will appear in the record and we will be committed to read it.

[The statement of Mr. Daub and a copy of H.R. 3900 follow:]

PREPARED STATEMENT OF HON. HAL DAUB

Mr. Chairman, I am encouraged to see that our subcommittee is at long last addressing what is arguably the most pressing concern of an aging America, the costs of long-term health care.

As the chairman is well aware, I have devoted a great deal of effort in my capacity as a member of the Ways and Means Health Subcommittee to the resolution of the long-term care cost dilemma.

Earlier this year, I and my distinguished subcommittee colleague, Brian Donnelly of Massachusetts, introduced legislation, H.R. 3900, aimed at meeting the long-term care challenge through a collaborative venture on the parts of the public and private sectors.

Combining a limited entitlement expansion with a variety of tax incentives, the Daub-Donnelly would offer the best of what both the Federal government and the private sector have to offer in helping Americans avoid the financial and emotional devastation of long-term care costs.

While I realize that H.R. 3900 is hardly perfect, I maintain that we have at least presented a working model for a viable long-term health care plan.

It is my hope, Mr. Chairman, that these proceedings and proceedings to follow will bear out my contention that final and effective long-term care legislation necessarily will represent a marriage of the public and private sectors.

I commend the chairman for his commitment and leadership and for his studied and expert approach to a very difficult issue.

The following are synopses of the new Daub-Donnelly bill's major provisions:

Provides Medicare coverage of home health services and nursing care

Allows for Medicare reimbursement of home health care services as needed, without regard to the "part time, intermittent care" standard of present law

Requires beneficiaries to pay a deductible which increases progressively in relation to beneficiary income

Bases Medicare reimbursements for nursing home care upon the lower of customary or reasonable charges for health services (as currently defined in the law)

Provides for benefit eligibility of all Medicare beneficiaries without the payment of any type of premium

[The bill is financed by channeling 60% of already-scheduled increases in the Social Security (combined OASDI) tax rates to the Medicare Hospital Insurance (HI) fund. Additional funding is secured by slightly raising the amount of income subject to the HI portion of the entire OASDI tax (the amount subject to the HI tax would be 110% of the amount subject to the combined OASDI tax).]

Permits—as incentives for the individual purchase of long term care insurance—(1) the treatment of the costs of long term care insurance premiums as an above-the-line deduction for income tax purposes (applies to individuals over the age of 50); (2) the tax free withdrawal of monies from an IRA account as long as those monies are applied toward the purchase of long term care insurance; and (3) the tax free conversion (i.e., cashing in) of life insurance policies as long as the resulting funds are applied, as in the case of the IRA's, toward the purchase of long term care insurance.

Provides incentives for employers to offer long term health care benefits for current and retired employees through pension plans.

Above all, addresses the true catastrophic health care issue: long term care and nursing home costs.

I

100TH CONGRESS
2D SESSION

H. R. 3900

To amend title XVIII of the Social Security Act to provide long-term care benefits under the medicare program and to amend the Internal Revenue Code of 1986 to provide for incentives for individuals and employers to purchase long-term care insurance.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 3, 1988

Mr. DAUB (for himself and Mr. DONNELLY) introduced the following bill; which was referred jointly to the Committees on Ways and Means and Energy and Commerce

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A BILL

To amend title XVIII of the Social Security Act to provide long-term care benefits under the medicare program and to amend the Internal Revenue Code of 1986 to provide for incentives for individuals and employers to purchase long-term care insurance.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Long-Term Health Care Amendments of 1988".

TITLE I—MEDICARE LONG-TERM CARE BENEFITS

SEC. 101. NEW PART C.

(a) IN GENERAL.—Title XVIII of the Social Security Act is amended by redesignating part C as part D and by inserting after part B the following new part:

"PART C—LONG-TERM CARE BENEFIT PROGRAM

"ESTABLISHMENT OF LONG-TERM CARE PROGRAM FOR THE AGED AND DISABLED

"SEC. 1851. There is hereby established an insurance program to provide long-term care benefits in accordance with the provisions of this part for aged and disabled individuals who are entitled to benefits under the hospital insurance program.

"SCOPE OF BENEFITS; INCOME-RELATED DEDUCTIBLE

"SEC. 1852. (a) SCOPE OF BENEFITS.—The benefits provided to an individual by the insurance program established by this part shall consist of entitlement to have payment made on his behalf (subject to the provisions of this part) for—

"(1) home health services, and

"(2) nursing care.

In this part, the term 'home health services' has the meaning given such term in section 1861(m) with the omission of any reference to 'part-time or intermittent'.

"(b) Deductible.—Before applying section 1853(b) with respect to expenses incurred by an individual during any calendar year, the total amount of the expenses incurred by such individual during such year and the 3 month period preceding the year (which would, except for this subsection, constitute incurred expenses from which benefits payable under section 1853(b) are determinable) shall be reduced by a deduction equal to the long-term care deductible established under subsection (c) for that year for that individual.

"(c) Amount of Long-Term Care Deductible.—(1) Subject to paragraph (2), the long-term care deductible for an individual for a calendar year is equal to the sum of—

"(A) $5,000, plus

"(B) in the case of an individual with income (as determined by the Secretary) in the previous calendar year which—

"(i) exceeded $10,000, but did not exceed $20,000, 70 percent of the amount by which such income exceeded $10,000;

"(ii) exceeded $20,000, but did not exceed $30,000, the sum of—

"(I) the percent specified in clause (i) times $10,000, and

"(II) 80 percent of the amount by which such income exceeded $20,000; or "(iii) exceeded $30,000, the sum of—

"(I) the percent specified in clause (i) times $10,000,

"(II) the percent specified in clause (ii)(II) times $10,000, and

"(III) 90 percent of the amount by which such income exceeded $30,000.

For calendar years after 1989, each dollar amount specified in the previous table in the previous year (after any application of this sentence) shall be increased by the same percentage as the applicable increase percentage (established under section 215(i) during that previous year) and, if not a multiple of $10, rounded to the nearest $10.

"(2)(A) The Secretary shall estimate, in October before each year (beginning with 1988), if the additional amounts of revenues to be received by the Federal Hospital Insurance Trust Fund in that succeeding year because of the amendments made by section 102 of the Long-Term Health Care Amendments of 1988, is less than the amount of expenditures expected to be made under this part during that succeeding year.

"(B) If the Secretary estimates that such a deficit will occur for a year, the Secretary shall increase the deductible amounts otherwise applicable under paragraph (1) for the year in a manner so that—

"(i) expenditures under this part for that year will approximate, and not exceed, the amount of revenue described in subparagraph (A), and

"(ii) ½ of the expenditure reductions are achieved through an increase in the amount specified in paragraph (1)(A) and ½ of such reductions are achieved through an increase in the percents specified in clauses (i), (ii)(II), and (iii)(III) of paragraph (1)(B).

"CONDITIONS OF AND LIMITATIONS ON PAYMENT FOR SERVICES

"SEC. 1853. (a) REQUIREMENTS OF REQUESTS AND CERTIFICATIONS.—Payment under this part for services furnished an individual may be made only to providers of services which are eligible therefor under section 1866 and only if—

"(1) written request, signed by such individual, except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner, and by such person or persons as the Secretary may by regulation prescribe, no later than the close of the period of 3 calendar years following the year in which such services are furnished (deeming any services furnished in the last 3 calendar months of any calendar year to have been furnished in the succeeding calendar year) except that where the Secretary deems that efficient administration so requires, such period may be reduced to not less than 1 calendar year;

"(2) a physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations) that—

"(A) in the case of nursing facility care, such services are or were required to be given because the individual needs or needed nursing care (provided directly by or requiring the supervision of skilled or licensed nursing personnel) or other rehabilitation services, which can only be provided in a nursing facility on an inpatient basis; or

"(B) in the case of home health services—

"(i) such services are or were required because the individual needs or needed nursing care or physical or speech therapy or, in the case of an individual who has been furnished home health services based on such a need and who no longer has such a need for such care or therapy, continues or continued to need occupational therapy;

"(ii) a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician; and

"(iii) such services are or were furnished while the individual was under the care of a physician.

To the extent provided in regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where, at a later date, a physician makes the certification of the kind provided in the respective subparagraph, but only where such certification is accompanied by such medical and other evidence as may be required by such regulations. With respect to the physician certification required by paragraph (2)(B) for home health services furnished to any individual by a home health agency (other than an agency which is a governmental entity) and with respect to the establishment and review of a plan for such services, the Secretary shall prescribe regulations which prohibit a physician who has a significant ownership interest in, or a significant financial or contractual relationship with, such home health agency from performing such certification and from establishing or reviewing such plan, except that such prohibition shall not apply with respect to a home health agency which is a sole community home health agency (as determined by the Secretary). For purposes of the preceding sentence, service by a physician as an uncompensated officer or director of a home health agency shall not constitute having a significant ownership interest in, or a significant financial or contractual relationship with, such agency.

"(b) AMOUNT PAID TO PROVIDERS.—In the case of each individual who is covered under the insurance program established by this part and who incurs expenses for services with respect to which benefits are payable under this part, subject to section 1852(b), the amount paid to any provider of services with respect to the services for which payment may be made under this part shall be—

"(1) the lesser of (A) the reasonable cost of such services, as determined under section 1861(v), or (B) the customary charges with respect to such services, or

"(2) if such services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this provision), free of charge or at nominal charges to the public, the amount determined on the basis of those items (specified in regulations prescribed by the Secretary) included in the determination of such reasonable cost which the Secretary finds will provide fair compensation to such provider for such services.

"(c) NO PAYMENTS TO FEDERAL PROVIDERS OF SERVICES.—Subject to section 1880, no payment may be made under this part to any Federal provider of services, except a provider of services which the Secretary determines is providing services to the public generally as a community institution or agency; and no such payment may be made to any provider of services for any item or service which such provider is obligated by a law of, or a contract with, the United States to render at public expense.

"PAYMENT TO PROVIDERS OF SERVICES

"SEC. 1854. (a) The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to services furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate (but not less often than monthly) and prior to audit or settlement by the General Accounting Office, from the Federal Hospital Insurance Trust Fund, the amounts so determined, with necessary adjustments on account of previously made overpayments or underpayments; except that no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period.

"(b) No payment may be made under this part with respect to any services furnished an individual to the extent that such individual is entitled (or would be entitled except for section 1813) to have payment made with respect to such services under part A.

"(c) The provisions of sections 1815(d) (relating payment of interest on overpayments and underpayments) and 1816 (relating to fiscal intermediaries) shall apply to payment for home health services and nursing care under this part in the same manner as they apply to payment for home health services and post-hospital extended care services under part A, except that the provisions of section 1815(d) shall not apply to the extent that interest is payable under 1816(c)(2)(C) (as applied under this subsection).

"ELIGIBLE INDIVIDUALS; COVERAGE PERIOD

"SEC. 1855. (a) Every individual who is entitled to hospital insurance benefits under part A is entitled to long-term care benefits under this part.

"(b) The period during which an individual is entitled to benefits under the insurance program established by this part be the same as the period in which the individual is entitled to benefits under part A. No payments may be made under this part with respect to the expenses of an individual unless such expenses were incurred by such individual during a period in which they were entitled to benefits under part A.".

SEC. 102. FINANCING.

(a) ADJUSTMENT IN FICA/HI TAX RATES.—

(1) TAX ON EMPLOYEES.—Section 3101 of the Internal Revenue Code of 1986 (relating to rate of tax on employees) is amended—

(A) in subsection (a)—

(i) by striking "or 1989",

(ii) by striking the last line and inserting the following:

"1989	5.84 percent
"1990 or thereafter	5.9 percent."; and

(B) in subsection (b)—

(i) by striking "and" at the end of paragraph (5);

(ii) in paragraph (6), by inserting "and before January 1, 1988" after "1985" and by striking the period and inserting a semicolon; and

(iii) by adding at the end the following new paragraphs:

"(7) with respect to wages paid during calendar year 1989, the rate shall be 1.67 percent; and

"(8) with respect to wages paid after December 31, 1989, the rate shall be 1.75 percent.".

(2) TAX ON EMPLOYERS.—Section 3111 of such Code (relating to rate of tax on employers) is amended—

(A) in subsection (a)—

(i) by striking "or 1989",

(ii) by striking the last line and inserting the following:

"1989	5.84 percent
"1990 or thereafter	5.9 percent."; and

(B) in subsection (b)—

(i) by striking "and" at the end of paragraph (5);

(ii) in paragraph (6), by inserting "and before January 1, 1988" after "1985" and by striking the period and inserting a semicolon; and

(iii) by adding at the end the following new paragraphs:

"(7) with respect to wages paid during calendar year 1989, the rate shall be 1.67 percent; and

"(8) with respect to wages paid after December 31, 1989, the rate shall be 1.75 percent.".

(3) Tax on Self-Employed.—Section 1401 of such Code (relating to rate of tax on self-employment income) is amended—

(A) in subsection (a), by striking the line beginning with "December 31, 1987" and inserting the following:

"December 31, 1987	January 1, 1989	12.12
"December 31, 1988	January 1, 1990	11.68
"December 31, 1989		11.80."; and

(B) in subsection (b), by striking the line beginning with "December 31, 1985" and inserting the following:

"December 31, 1985	January 1, 1988	2.90
"December 31, 1987	January 1, 1990	3.34
"December 31, 1989		3.5.".

(b) 10 Percent Increase in Contribution and Benefit Base Applicable for Hospital Insurance Tax.—Section 230 of the Social Security Act (42 U.S.C. 430) is amended—

(A) in subsection (a), by adding at the end the following new sentence: "Notwithstanding any other provision of this Act or of the Internal Revenue Code of 1986, the contribution and benefit base which shall apply for purposes of the hospital insurance tax under section 1401(b), 3101(b), or 3111(b) of the Internal Revenue Code of 1986 shall be 110 percent of the contribution and benefit base otherwise applicable.".

(c) Effective Dates.—

(1) Employee and employer taxes.—The amendments made by paragraphs (1) and (2) of subsection (a) and by subsection (b), insofar as it relates to the hospital insurance tax imposed under sections 3101(b) or 3111(b) of the Internal Revenue Code of 1986, shall apply to remuneration paid after December 31, 1988.

(2) SELF-EMPLOYMENT TAXES.—The amendments made by paragraph (3) of subsection (a) and subsection (b), insofar as it relates to the hospital insurance tax imposed under section 1401(b) of the Internal Revenue Code of 1986, shall apply to taxable years beginning after December 31, 1988.

SEC. 103. AMENDMENTS RELATING TO SCOPE OF BENEFITS.

(a) NURSING CARE DEFINED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

"Nursing Home Care; Nursing Facility

"(jj)(1) The term 'nursing home care' means extended care services (as defined in subsection (h)) and items and services which would constitute extended care services (as so defined) if 'nursing facility' were substituted for 'skilled nursing facility' and if 'licensed professional nurse' were substituted for 'registered professional nurse' each place either appears.

"(2) The term 'nursing facility' means an institution which—

"(A) is a skilled nursing facility (as defined in subsection (j)), or

"(B) is an intermediate care facility (as defined in the first sentence of section 1905(c)) which—

"(i) has in effect a transfer agreement (meeting the requirements of subsection (l)) with one or more hospitals having agreements in effect under section 1866, and

"(ii) meeting the requirements of paragraphs (4), (5), and (7) through (15).".

(b) EXCLUSION STANDARDS.—Section 1862(a) of such Act (42 U.S.C. 1395y(a)) is amended, in the matter before paragraph (1), by striking "or part B" and inserting ", part B, or part C".

SEC. 104. MISCELLANEOUS AMENDMENTS.

(a) USE OF FEDERAL HOSPITAL INSURANCE TRUST FUND.—Section 1817 of the Social Security Act (42 U.S.C. 1395i(h)) is amended—

(1) in subsection (b), by adding at the end the following new sentence: "In reporting concerning the Trust Fund, the Board of Directors shall provide for a separate accounting of the amount of the additional taxes deposited into the Trust Fund as a result of the amendments made by section 102 of the Long-Term Health Care Amendments of 1988 and of the disbursements made from the Trust Fund with respect to benefits paid under part C.", and

(2) in subsection (h), by inserting "or part C" after "this part".

(b) TREATMENT AS PROVIDER OF SERVICES.—(1) Section 1861(u) of such Act (42 U.S.C. 1395x(u)) is amended by inserting "nursing facility," after "skilled nursing facility,".

(2) Section 1866(a)(2)(A)(i) of such Act (42 U.S.C. 1395cc(a)(2)(A)(i)) is amended by inserting "section 1852(b)," after "section 1833(b),".

(3) Section 1880 of such Act (42 U.S.C. 1395qq) is amended—

(A) by inserting ", nursing facility," after "hospital" each place it appears,

(B) by inserting ", nursing facilities" after "hospitals" each place it appears, and

(C) in subsection (a), by striking "and 1835(d)" and inserting ", 1835(d), and 1853(c)".

(c) PAYMENTS NOT SECONDARY TO EMPLOYER PLANS.—Section 1862(b)(3)(A) of such Act (42 U.S.C. 1395y(b)(3)(A)) is amended by inserting "(other than under part C)" after "under this title" in clauses (i) and (ii).

(d) MISCELLANEOUS.—(1) Section 1861(r)(3) of such Act (42 U.S.C. 1395x(r)(3)) is amended by striking "and 1835" and inserting "1835, and 1853".

(2) Section 1861(v) of such Act (42 U.S.C. 1395x(v)) is amended—

(A) in subparagraphs (E), (J), and (O) of paragraph (1) and in paragraph (3), by striking "skilled" each place it appears;

(B) in paragraphs (2)(A) and (3), by inserting ", nursing care," before "or post-hospital";

(C) in paragraph (2)(B), by striking "or part B" and inserting ", part B, or part C"; and

(D) in paragraph (3), by inserting "or part C" after "part A".

(3) Subsections (l)(1), (w)(1), and (z) of section 1861 of such Act (42 U.S.C. 1395x) are amended by striking "skilled" each place it appears.

(4) Section 226(c)(1) of such Act (42 U.S.C. 426(c)(1)) is amended by striking "part C" and inserting "part D".

SEC. 105. EFFECTIVE DATE.

The amendments made by this title (other than section 102) shall apply to expenses incurred for services furnished on or after January 1, 1989.

TITLE II—INCENTIVES FOR INDIVIDUALS TO PURCHASE LONG-TERM CARE INSURANCE

SEC. 201. TAX DEDUCTION FOR PAYMENT OF CERTAIN QUALIFIED LONG-TERM CARE INSURANCE PREMIUMS.

(a) In General.—Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to additional itemized deductions for individuals) is amended by redesignating section 220 as section 221 and by adding after section 219 the following new section:

"SEC. 220. QUALIFIED LONG-TERM CARE INSURANCE PREMIUMS.

"(a) DEDUCTION ALLOWED.—In the case of an individual, there shall be allowed as a deduction an amount equal to the qualified long-term care insurance premiums paid by the taxpayer during the taxable year on behalf of any eligible beneficiary.

"(b) LIMITATIONS.—

"(1) DEDUCTION NOT TO EXCEED UNEARNED INCOME.—The maximum amount allowable as a deduction under subsection (a) in respect of amounts paid by a taxpayer during a taxable year shall not exceed an amount equal to the income (other than earned income (as defined in section 911(d)(2)(A))) of the taxpayer for the taxable year.

"(2) DEDUCTION NOT TO EXCEED $1,500 PER ELIGIBLE BENEFICIARY.—The maximum amount allowable as a deduction under subsection (a) in respect of amounts paid by a taxpayer during a taxable year on behalf of an eligible beneficiary shall not exceed $1,500.

"(c) DEFINITIONS.—For purposes of this section:

"(1) QUALIFIED LONG-TERM CARE INSURANCE PREMIUM.—The term 'long-term care insurance premium' means, with respect to a taxpayer, any amount paid by the taxpayer as a premium for a qualified long-term care insurance policy.

"(2) QUALIFIED LONG-TERM CARE INSURANCE POLICY.—

"(A) IN GENERAL.—Subject to subparagraph (B), the term 'qualified long-term care insurance policy' means an insurance policy or rider, issued by a qualified issuer, and certified by the Secretary of Health and Human Services (in accordance with procedures similar to the procedures prescribed in section 1882 of the Social Security Act (42 U.S.C. 1385ss) used in the certification of medicare supplemental policies (as defined in subsection (g)(1) of such section)) to be advertised, marketed, offered, or designed to provide coverage for—

"(i) not less than 12 consecutive months for each covered person,

"(ii) on an expense incurred, indemnity, or prepaid basis,

"(iii) for 1 or more medically necessary—

"(I) diagnostic services,

"(II) preventive services,

"(III) therapeutic services,

"(IV) rehabilitative services,

"(V) maintenance services, or

"(VI) personal care services, and

"(iv) provided in a setting other than an acute care unit of a hospital.

"(B) COVERAGE SPECIFICALLY EXCLUDED.—Such term does not include any insurance policy or rider which is offered primarily to provide any combination of the following kinds of coverage:

"(i) Basic Medicare supplement coverage.

"(ii) Basic hospital expense coverage.

"(iii) Basic medical-surgical expense coverage.

"(iv) Hospital confinement indemnity coverage.

"(v) Major medical expense coverage.

"(vi) Disability income protection coverage.

"(vii) Accident only coverage.

"(viii) Specified disease coverage.

"(ix) Specified accident coverage.

"(x) Limited benefit health coverage.

"(3) QUALIFIED ISSUER.—The term 'qualified issuer' means any of the following:

"(A) Private insurance company.

"(B) Fraternal benefit society.

"(C) Nonprofit health corporation.

"(D) Nonprofit hospital corporation.

"(E) Nonprofit medical service corporation.

"(F) Prepaid health plan.

"(4) ELIGIBLE BENEFICIARY.—The term 'eligible beneficiary' means, with respect to a taxpayer, any of the following who has attained the age of 50 years:

"(A) The taxpayer.

"(B) The spouse of the taxpayer.

"(C) Any dependent (as defined in section 152) of the taxpayer.".

(b) DEDUCTION ALLOWED IN ARRIVING AT ADJUSTED GROSS INCOME.—Subsection (a) of section 62 of such Code (defining adjusted gross income) is amended by adding at the end the following new paragraph:

"(13) QUALIFIED LONG-TERM CARE INSURANCE PREMIUMS.—The deduction allowed by section 220."

(c) CLERICAL AMENDMENT.—The table of sections for part VII of subchapter B of chapter 1 of such Code is amended by striking the last item and inserting the following new items:

"Sec. 220. Qualified long-term care insurance premiums.
"Sec. 221. Cross references."

(d) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply to amounts paid after December 31, 1988, in taxable years ending after that date.

SEC. 202. EXCLUSION FROM GROSS INCOME FOR AMOUNTS WITHDRAWN FROM INDIVIDUAL RETIREMENT PLANS FOR LONG-TERM CARE INSURANCE PREMIUMS. [from H.R. 2997]

(a) IN GENERAL.—Subsection (d) of section 408 of the Internal Revenue Code of 1986 (relating to tax treatment of distributions from individual retirement plans) is amended by adding at the end thereof the following new paragraph:

"(7) DISTRIBUTIONS FOR QUALIFIED LONG-TERM CARE INSURANCE PREMIUMS.—No amount (which but for this paragraph would be includible in the gross income of the payee or distributee under paragraph (1)) shall be included in gross income during the taxable year if—

"(A) the payee or distributee has attained age 59½ on or before the date of the distribution, and

"(B) the distribution is used during such year to pay premiums for any qualified long-term care insurance policy (as defined in section 220(c)(2)) for the benefit of the payee or distributee or the spouse of the payee or distributee if such spouse has attained age 59½ on or before the date of the distribution.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 1988.

SEC. 203. EXCLUSION FROM GROSS INCOME FOR AMOUNTS OTHERWISE INCLUDIBLE ON THE SURRENDER OR CANCELLATION OF ANY LIFE INSURANCE POLICY WHICH ARE USED FOR LONG-TERM CARE INSURANCE PREMIUMS. [from H.R. 2998]

(a) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to items specifically excluded from gross income) is amended by redesignating section 135 as section 136 and by inserting after section 134 the following new section:

"SEC. 135. AMOUNTS RECEIVED ON CANCELLATION, ETC. OF LIFE INSURANCE CONTRACTS AND USED TO PAY PREMIUMS FOR QUALIFIED LONG-TERM CARE INSURANCE.

"No amount (which but for this section would be includible in the gross income of an individual) shall be included in gross income on the whole or partial surrender, cancellation, or exchange of any life insurance contract during the taxable year if—

"(1) such individual has attained age 65 on or before the date of the transaction, and

"(2) the amount otherwise includible in gross income is used during such year to pay premiums for any qualified long-term care insurance policy (as defined in section 220(c)(2)) for the benefit of such individual or the spouse of such individual if such spouse has attained age 65 on or before the date of the transaction.".

(b) CLERICAL AMENDMENT.—The table of sections for such part III is amended by striking out the last item and inserting in lieu thereof the following new items:

"Sec. 135. Amounts received on cancellation, etc. of life insurance contracts and used to pay premiums for qualified long-term care insurance.
"Sec. 136. Cross references to other Acts."

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1988.

TITLE III—INCENTIVES FOR EMPLOYERS TO PROVIDE GROUP LONG-TERM CARE

SEC. 301. GROUP LONG-TERM CARE BENEFITS MAY BE PROVIDED BY PENSION PLANS.

(a) IN GENERAL.—Subsection (a) of section 401 of the Internal Revenue Code of 1986 (relating to qualified pension, profit-sharing, and stock bonus plans) is amended by inserting after paragraph (28) the following new paragraph:

"(29) LONG-TERM CARE BENEFITS PERMITTED.—

"(A) IN GENERAL.—A trust forming part of a pension plan shall not be treated as failing to constitute a qualified trust under this section merely because such plan provides for the payment of benefits for qualified long-term health care of employees or retired employees.

"(B) QUALIFIED LONG-TERM HEALTH CARE.—For purposes of subparagraph (A), the term 'qualified long-term health care' means benefits of the type described in section 220(c)(2)(A)."

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to years beginning after December 31, 1988.

Chairman **Stark**. Thank you very much.

Your testimony was helpful and provocative and I hope we can call on your assistance as we wind through this thorny problem in the years ahead.

Mr. **Wiener**. Thank you.

Chairman **Stark**. Our next witnesses will comprise a panel of senior citizens groups: The American Association of Retired Persons, represented by Lovola Burgess, the vice president, Albuquerque, NM; the National Council of Senior Citizens, represented by one of America's great senior citizens, William Dodds, executive board member; and the National Committee to Preserve Social Security and Medicare, represented by Martha McSteen, senior legislative counsel.

The Chair is constrained to make a comment before the witnesses get started.

In an effort to be bipartisan, I would suggest that while the administration has seen fit to be able to deal with Darth Vader and the forces of evil, and meet with the Russians, I am sure the Russians are under a constraint to know that that accommodation may disappear if they don't behave as it is with the National Committee to Preserve Social Security and Medicare.

It is not indeed their representatives or their policies that have given cause for many Members of Congress to be concerned, but it is indeed the marketing practices in this Member's opinion of almost obscene misrepresentation to scare senior citizens.

I have some feeling that that may change and I only admonish that group that if it does not, this honeymoon will end rather abruptly and I would hope that a word to the wise is sufficient and that we will have a third advocate for seniors for many years to come who will be able to take their place along with the other advocates who are with us today whose representations are unblemished and who have done excellent work in representing the seniors.

Enough said.

Our first witness will represent the American Association of Retired Persons, Lovola Burgess.

All of your statements will appear in the record in their entirety. You may wish to summarize them or expand on them.

I know that the members of the committee have had them and are reading them. Our staffs have highlighted them and we may want to expand on them in the questioning period, but having said that, you may proceed in any manner you are comfortable with.

STATEMENT OF LOVOLA BURGESS, VICE PRESIDENT, AMERICAN ASSOCIATION OF RETIRED PERSONS, ACCOMPANIED BY PATRICIA SMITH, SENIOR COORDINATOR, HEALTH ISSUES, FEDERAL AFFAIRS DEPARTMENT

Ms. **Burgess**. Thank you very much, Chairman Stark.

My name is Lovola Burgess, and I am from Albuquerque, NM. I am vice president of the American Association of Retired Persons.

I want to commend you for having these hearings and for furthering the discussion and the debate on long-term care. I am finding the morning very stimulating.

Long-term care is, as you know, potentially needed by persons of all ages. Seven million American households today have a child or adult member who is chronically ill or disabled.

Long-term care leads almost inevitably to an unmanageable financial burden, yet perhaps even more important we must consider the hidden costs of suffering, deprivation and isolation of those of all ages who get no or inadequate care. The need among individuals of all ages along with the burden on the families, impoverishment and lack of care demonstrate the need for a new approach to financing and delivering long-term care.

Our society currently is paying the cost of long-term care, but in a way that places inordinate burdens on the victims of chronic illness and their families. The issue for Federal policy is how to spread the costs so that the burden to any one person will be small, while offering protection and appropriate care to all.

AARP believes that the answer will be found in a social insurance rather than a welfare approach. Social insurance would require financial contributions from all members of society, and would provide protection to all who need care.

Our view is that Americans of all ages should have access to a new Federal long-term care program. The program should offer a wide range of services in the least restrictive setting that is possible.

The Federal Government should play a strong administrative role to ensure that consistent standards for eligibility, quality of care, and reimbursement are maintained nationwide, and that cost increases are controllable. An important role in administration may also lie with the States, because a number of them have already set up good service delivery and case management systems.

AARP is studying various funding mechanisms, including beneficiary copayments, deductibles and premiums; payroll, estate and gift taxes, and maintenance of government spending for current long-term care programs.

We are guided by several general assumptions.

First, the burden of paying for long-term care should be shared between the retired and working age populations.

Second, the cost should not add to the Federal deficit.

Third, mechanisms must be established to keep costs and use of services under control.

And finally, the system must not create perverse incentives for delivery of care in a particular setting such as the nursing home.

AARP has serious reservations about proposals that would require individuals to pay for their own benefits for months, 1 or 2 years. A majority of older persons who have long nursing home stays exhaust their resources within a year.

Under such proposals, all the new costs of the program would go to aid those with the means to survive the time deductible. The most likely candidate for nursing home care is a nonmarried woman age 80-and-over with very low income. A 1-year time deductible for nursing home expenses would cost about $25,000—an amount beyond the resources of three quarters of women who live alone.

Although private insurance must play an important role, most persons believe that they don't need it or that they can't afford it.

In our view, private insurance must be available as an option to help beneficiaries meet the cost of copayments, deductibilities, and services not covered under the public program. Purchasers of such policies also need to be protected as you have proposed in H.R. 5085.

In conclusion, I would like to emphasize three points.

One, the costs of long-term care are now borne by society, but in a very uneven way.

Two, a public program would spread those costs more affordably across the population while assuring care for all when needed.

And three, AARP looks forward to working with the Congress and the next administration to develop workable solutions.

I would like to say in closing that we believe that Americans really are ready to accept this challenge to look at long-term care not only for ourselves, but also for current and future generations.

Thank you, Mr. Chairman.

Chairman STARK. Thank you, Ms. Burgess.

[The statement of Ms. Burgess follows:]

STATEMENT OF LOVOLA BURGESS, VICE PRESIDENT, AMERICAN ASSOCIATION OF RETIRED PERSONS

Thank you, Chairman Stark. My name is Lovola Burgess and I am Vice President of the American Association of Retired Persons (AARP). On behalf of our membership, I want to commend you for holding these hearings and, by doing so, for advancing the debate on long-term care around the nation. AARP believes that this issue needs careful debate and discussion. We, as a nation, must have a strong commitment to protect persons of all ages against the catastrophic problem of long-term illness and disability.

My testimony will show why AARP believes there is a need for a new long-term care system based on the principle of social insurance. It will also discuss the broad outlines of the type of system AARP favors.

THE NEED FOR A NEW LONG-TERM CARE SYSTEM

Long-term care is potentially needed by persons of all ages, not just older persons. Seven million American households today have a child or adult member who is chronically ill or disabled. Millions of chronically ill children and adults who need long-term care are outside of the current Medicare/OASDI system and are not covered under private insurance. Also, as medical technology has advanced, many people who need long-term care are now living longer than they would have in the past. For instance, children with lung disease, who 15 years ago would have died, now are able to live with the assistance of mechanical respirators. They can be dependent on respirators for years. These children represent only one population needing long-term care.

As people age they frequently fall victim to chronic illnesses such as Alzheimer's disease and osteoporosis. These illnesses lead to a long, slow decline in mental and/or physical functioning. People with chronic illnesses may need acute care for major bouts with other conditions such as heart attacks but their dominant need is for long-term care. A person with Alzheimer's disease needs someone to monitor his behavior and to help with such basics as bathing and dressing. Osteoporosis can put a woman in a hospital because of a broken hip; but after the hospitalization, she will need help moving around the house and with preparation of meals until her bones mend.

Disability rates increase markedly with age. For example, only 7% of persons aged 65-74 need help with one or more "instrumental" or "basic" activities of daily living, compared with almost 45% of people aged 85 or older. And, this age group is the fastest growing segment of our population.

The need for a new system of long-term care extends beyond those who need the care to those--family and friends--who provide personal care and financial support. Family members are the cornerstone of the long-term care delivery system for the elderly. These caregivers typically provide care every day. According to the 1982 National Long-Term Care Survey, almost 3 out of 4 functionally impaired older Americans rely exclusively on unpaid care provided by families and friends. Another 21% rely on a combination of support from families and paid providers. Only 5% of the elderly rely solely on paid providers.

The need for long-term care leads almost inevitably to an unmanageable financial burden because the cost of care is often enormous. The cost of a year in a nursing home averages $25,000. Nursing home stays account for over 80% of the expenses incurred by older people who experience very high out-of-pocket costs for health care. Since few people can afford the expense of an extended nursing home stay, many end up on Medicaid after a financial catastrophe has occurred. While Medicaid picks up a substantial share, more than half of nursing home costs are paid out of the pockets of residents and their families. The family's share of this burden has been rising in recent years.

Perhaps most important of all are the hidden costs of suffering, deprivation, and isolation for those in our society who get no care or inadequate help. Data from the National Long-Term Care Survey indicate that large numbers of functionally impaired older persons in the community, particularly the severely disabled, have unmet needs for assistance. For example, 77% of older people with three or more limitations in their activities of daily living reported they needed more help.

These factors--the need for long-term care among persons of all ages, the burden on families, impoverishment, and lack of care--demonstrate the need for a new approach to financing and delivering long-term care. AARP recommends a social insurance approach that protects all Americans from impoverishment and lack of care. Social insurance would require financial contributions from all members of society and would provide protection to all who need long-term care. The remainder of my testimony discusses the Association's recommendations for a long-term care program based on social insurance.

AARP'S RECOMMENDATIONS FOR A NEW LONG-TERM CARE SYSTEM

Our country's primary governmental long-term care program, Medicaid, is inadequate for several reasons: 1) the Medicaid program does not cover home care except through special waivers; 2) among the services which Medicaid can provide, the degree of coverage varies dramatically from state to state; and 3) because it is a welfare program, Medicaid often robs families of dignity and independence. Beyond Medicaid, our society is paying the costs of long-term care but in a way that places burdens on the victims of chronic illness and their families. The question before us is how to spread the burden so that the costs to any one person will be small, while offering protection and appropriate care to all. The answer is a social insurance, rather than a welfare, approach.

The nature of the need for long-term care lends itself to an insurance approach based on shared risk for several reasons: 1) relatively few persons in our society need long-term care at any one time; 2) it is nearly impossible to predict who these individuals will be; and 3) the lifetime risk of needing nursing home care is much higher than most people think. (The lifetime risk of institutionalization at age 65 ranges from 36% to 63%.) This combination of factors shows the need for and the utility of an insurance approach to universal protection. The costs to any one person will be small, while offering protection to all against financial devastation.

Americans of all ages recognize that long-term care is a growing necessity. While many underestimate the costs and the likelihood of their needing such service, surveys have demonstrated that the public is willing to participate in a social insurance approach.

AARP's proposals for long-term health care encompass a number of issues and concerns. All Americans, regardless of age should be eligible for long-term care programs. The services offered by a nationwide long-term care program should be inclusive. Nursing home care, day care, and in-home care all constitute particular and valuable resources to severely-disabled Americans who require assistance.

Some state governments already have experience in administering long-term care programs, and the Federal government would be well-served by a study of their experiences. These states have introduced a variety of programs and have demonstrated how flexibility and creativity in providing care can keep costs down while maintaining quality.

The federal government, however, must oversee development of long-term care programs to ensure that all Americans have access to quality services. Oversight must include strong standards relating to eligibility, services, administration, quality of care and provider reimbursement.

Eligibility for the New Program

Americans of all ages should have access to a new long-term care program. Chronically ill children and adults, as well as permanently disabled people, need access to long-term care. The lack of coverage of home and community services poses enormous burdens for these individuals and the families and friends who support them.

Eligibility for benefits should be based both on cognitive and functional impairments. Many people, particularly those who have Alzheimer's disease, may be physically capable of performing activities of daily living but unable to do so because of cognitive impairments. In determining eligibility for the program, in-person assessments and interviews with caregivers will be critical to gathering accurate information about individuals' functional status, social supports, and requirements for service arrangements.

The issues surrounding measurement of impairments are complex. For instance, there are several different scales for measuring the need for help with activities of daily living. In addition, it is not clear how to measure the need for help among different age groups. Thus, we recommend that a commission be established to assist the Secretary of Health and Human Services in developing appropriate measurements of disability, including a national, uniform assessment scale. The commission could provide advice on issues such as measurement of cognitive disabilities and the training needed by people who perform assessments.

Services under the New Program

AARP advocates that the program offer a wide range of long-term care services in the least restrictive setting possible. Services should include 1) in-home assistance, such as homemaker/chore services, personal care, home nursing care, and home-delivered meals; 2) community-based services, such as adult day care and transportation; 3) provision of home care services in special housing, such as congregate living arrangements; and 4) high quality institutional care. Another aspect of long-term care that merits consideration is respite care, which would provide short-term relief to unpaid caregivers, most of whom are family members. Such a broad range of services would ensure that people receive care that is tailored to their needs and circumstances. This would ensure the most efficient use of resources.

Administration of the New Program

The Federal government should take a strong role in administering the long-term care program to ensure that consistent standards for eligibility, quality of care, and reimbursement are maintained nationwide. Service delivery systems and the profiles of populations needing long-term care vary widely between and within the states. Thus, states will need to have some flexibility to tailor programs to meet their residents' distinctive needs. In addition, states should have a role in administration because a number of states have set up good service delivery systems.

Given that some states have more developed long-term care delivery systems than others, there is a need to phase in the new program. During the phase-in period, states should have technical assistance and start-up grants to enable them to develop their systems. The grants should be used to identify and fill gaps in service delivery networks. Since long-term care is currently biased toward institutional care, the initial emphasis should be on home and community-based services.

While the federal government has a very strong oversight responsibility and the states have a role in administering the new long-term care program, case management agencies have the potential to make the program work at the local level. Case managers could have responsibility for determining program eligibility and beneficiaries' need for care; developing the appropriate plan of care; arranging for delivery of services; and helping to ensure quality of care. States with the most comprehensive long-term care programs have found that giving independent case management agencies responsibility for assessing peoples' care needs and for developing care plans promotes program efficiency. Thus, case management seems to hold promise both for helping people to secure appropriate services and controlling use of services. Appropriate use of services is the key to keeping utilization and program costs under control. More research is needed to determine the best case management models and the appropriate role of these agencies.

Provider Reimbursement

Provider reimbursement systems for long-term care services should be designed to ensure the delivery of quality care. Payment should also ensure that cost increases are controllable. Reimbursement should be accepted as payment in full so that providers do not try to overcharge residents or clients. States, through their nursing home reimbursement systems, have begun to deal with these issues, and their experiences should be examined for applicability to a federal system.

For example, a number of states have developed "casemix" reimbursement systems that are designed to encourage nursing homes to accept heavy-care patients and deliver the appropriate amounts of care. New York's resource utilization group system (RUGS) pays nursing homes according to the amount of resources necessary to care for residents. The heavier the residents' care needs, the higher the level of reimbursement. Such reimbursement systems can improve access to nursing home care for the most vulnerable residents. Other states, such as Oregon, are beginning to develop nursing home reimbursement systems that would relate payment levels to resident outcomes. The idea is to go beyond casemix reimbursement and reward nursing homes that, in accordance with the plan of care, deliver care that improves or maintains residents' functioning. Providers would not be penalized when residents' functioning declines as a result of a debilitating disease.

To contain cost increases under Medicaid, almost all states use some form of prospective payment for nursing homes. This type of reimbursement system encourages facilities to contain costs because they are not reimbursed for charges that exceed the payment rate. For example, if a facility spends more than the prospective rate allows on administrative overhead, it will not be paid for the excess charges. Under any program, it is essential to use a payment system that keeps cost increases at reasonable levels. However, payment rates should not be so low as to undermine delivery of quality care.

With regard to payment for home care, there is less of a track record at the state level. Thus, there is a need for research to determine the best methods of paying for home care. The research should focus on prospective payment that accounts for casemix and outcomes. Such a payment system should also be flexible in order to account for the varying needs of home care clients. For instance, some people may need short periods of intensive skilled nursing care, and others may need long-term help with activities of daily living.

Quality Assurance

Under a new long-term care program, the federal and state governments would be taking a much more direct role in the financing of care. There should be a concomitant increase in the Federal government's responsibility for ensuring the quality of care that providers deliver. To ensure nursing home and home care quality, the new program should build upon the landmark Nursing Home Reform legislation the Congress passed in 1987 as part of the Omnibus Budget Reconciliation Act.

Additional quality standards for provider participation in the long-term care program should address the following goals: 1) plans of care and actual services delivered must meet client and caregivers' needs; 2) providers should not be allowed to discriminate in admissions or service delivery on the basis of payment source; and 3) social isolation of clients should be prevented. In addition, case managers should be involved in the quality assurance process by eliciting clients' views of the quality of care.

State ombudsperson programs also should be expanded to have responsibility for investigating and resolving complaints about all types of long-term care providers. Local consumer councils should be involved in such quality assurance efforts.

Financing the New Long-Term Care Program

Identifying realistic and adequate funding sources for a comprehensive long-term care program is one of the toughest issues which the Congress and advocates of long-term care must address. AARP advocates a social insurance approach to funding. Our attention is focused on beneficiary copayments, deductibles, and premiums; payroll, estate, and gift taxes; and maintenance of government spending on current long-term care programs such as Medicaid. In evaluating various possibilities, we are guided by several general assumptions.

1. The burden of paying for long-term care should be shared between the retired and working-age populations.

2. Any new federal commitment to long-term care should not add to the federal deficit.

3. Mechanisms must be established to keep cost and use of services under control.

4. The system must not create perverse incentives for delivery of care in a particular setting. For instance, copayments for home care should not be excessive compared to those for nursing home care.

CONSIDERATION OF OTHER APPROACHES TO LONG-TERM CARE

The Association views any piece of long-term care legislation in light of the broad outlines I just discussed. A number of limited approaches to long-term care are being considered in the Congress. Many of these approaches relate only to Medicare and Medicaid and would not provide a total solution. This section of my testimony will focus on four approaches:

1. Medicaid coverage supplemented with incentives for private long term care insurance;
2. comprehensive coverage with major "time deductibles";
3. comprehensive coverage immediately with time limits on benefits; and
4. expanded Medicaid.

Emphasizing Private Long-Term Care Insurance

Supporters of private long-term care insurance often advocate a public sector approach, either at the federal or state level, confined to improving incentives for the private sector and maintaining a limited Medicaid program. Such an approach might offer only improvements in tax laws covering insurance companies' activities, such as exempting interest on long-term care insurance reserves from taxation. Much broader--and more expensive--options would offer tax incentives to individuals who purchase insurance products. These broad tax benefits might be required to make coverage affordable and thus expand the numbers of people purchasing insurance.

Controversy also exists over what role Medicaid would play. Expansion of Medicaid could help fill in the gap between those who do not qualify for Medicaid but cannot afford insurance and the very poor who are now covered by Medicaid. In some states where these proposals have been debated, however, proponents have argued to keep Medicaid very restrictive so as not to make it an attractive option for persons deciding whether or not to purchase insurance.

The basic dilemma of this overall approach is that the most likely beneficiaries of tax incentives are those who are least in need of protection. The likely purchasers of private insurance are those with considerable resources and incomes (or employer-sponsorship). Would tax benefits bring in those with more modest incomes? And if so, at what cost? These issues are at the heart of such proposals. We do know that many of the tax benefits would go to the relatively affluent and that this system would leave at least some people with modest incomes uncovered. The size of that remaining gap is subject to considerable debate, as demonstrated by the Brookings Institution report on long-term care financing.

Encouragement of private sector efforts would probably be less amenable to later development of an extensive federal role. Strong resistance to change might come from the insurance industry and customers happy with their private insurance. If penetration of private insurance is very good, this would not constitute a problem. But, if as many analysts expect, insurance offers solutions to the long-term care problem for only a minority of the population, it may be difficult to expand coverage under a federal program to those of low or moderate incomes.

Nonetheless, long-term care insurance is already playing a role, and this private sector response will probably be necessary to provide a very comprehensive range of long-term care options. Therefore, any reliance on the private sector must involve protecting the purchasers of long-term care insurance. Purchasers should be shielded from inadequate policies and misleading advertising. There must be assurances that policies provide adequate disclosure of benefits and guarantee renewability. The government has a role in providing these protections. Chairman Stark has taken a leadership role on this issue because of his introduction of H.R. 5085. This bill will set federal guidelines for regulation of long-term care insurance policies and thus give consumers the protections they need.

Benefits with Long Waiting Periods

One of the most often discussed approaches to long-term care is a system that would require individuals to pay for their own nursing home and home health benefits for several months, a year, or two years. Only after that waiting period would public benefits begin. (Usually Medicaid would remain in place to cover those who cannot afford care during this waiting period.) These proposals generally assume--and some would require--the purchase of private insurance to cover the waiting period. In that sense, they are closely related to a private insurance approach.

This use of a "time deductible" would hold down the costs to the public sector since many persons do not have extended care needs. But, a majority of older persons who do have long stays exhaust their resources within a year. These individuals would then need to rely upon Medicaid. Their costs would be borne by the public system as they are now, but they would receive no new benefits from the social insurance component. That is, all the new costs of the program would go to aid those with the means, either in resources or insurance coverage, to survive the time deductible with some resources remaining. In this sense then, programs with long time deductibles may be most important in offering asset protections to the very wealthy and perhaps in encouraging the development of private sector approaches.

Supporters of this approach point to it as aiming more at the catastrophic side of long-term care rather than providing first dollar coverage. But for most older persons paying out-of-pocket or purchasing meaningful private insurance for a two-year, or even a one-year, deductible is beyond their reach. A one-year time deductible for nursing home expenses would cost about $25,000, an amount beyond the resources of three quarters of women who live alone, for example. Many of them could not afford insurance protection either. For such older Americans, a one-year deductible long-term care proposal would not offer catastrophic protection. Catastrophe would already have occurred. For those with high incomes and considerable resources, it would provide reasonable protection.

Time Limited Benefits

A very different approach to putting limits on long-term care would offer coverage with no initial waiting period. After receiving benefits for a period of time (for example, 6 months), individuals would begin spending their own resources for nursing care until they became eligible for Medicaid; or after the benefit period has lapsed, provisions would be in place to allow individuals to purchase insurance covering subsequent confinement. This approach assures access immediately and protects the assets of those likely to return to the community after a stay in a nursing home. Traditionally, long stayers have not returned home; and if no spouse is present, continued first dollar coverage would mainly protect assets for the heirs.

Such approaches often do not tackle holding down costs on the home health care side. Moreover, they send a message of hopelessness to individuals at the point when they are sick and alone. If spousal protections are maintained, cost savings from this approach would arise mainly from limiting benefits to single women in nursing homes, the vast majority of whom have few assets to spend down. Nonetheless, this approach represents an important recognition of placing the emphasis on access.

Expanded Medicaid

Few observers of current long-term care efforts under Medicaid argue that we adequately protect our citizens. But some advocate shoring up the current system as a modest approach to improving such coverage. Currently, 14 states effectively limit their coverage to the categorically needy. And some states with medically needy or expanded income eligibility programs have very restrictive limits that cover few additional persons.

National minimum standards are often proposed in efforts to expand Medicaid. There are a number of problems with this approach. First, Medicaid now has a strong bias toward nursing homes at a time when most experts agree that home health care needs to be expanded. Second, required spend down of assets and income are often viewed as unnecessarily restrictive. Finally, payment levels in many states have created problems in ensuring access to good quality nursing homes when such facilities believe they are not being fairly compensated.

Very quickly the "limited" approaches to expanding Medicaid can become expensive. Moreover, states that cannot or will not now expand their programs may be very reluctant partners. Some have also suggested that critical programs for low-income mothers and children might be cut back by further changing the original focus of the Medicaid program to expand long-term care benefits.

The recently released Brookings Institution study clearly demonstrates that if Medicaid essentially remains the same, its costs will grow rapidly as the costs of long-term care outstrip the growth in incomes of elderly families. And the expansions mentioned here could be quite expensive. Expanding Medicaid could hold down costs as compared to other options by continuing to require individuals to "spend down" to eligibility (albeit allowing them to keep more resources than under the present system) and from retaining the basic "welfare" approach to eligibility that often inhibits participation.

CONCLUSION

It is important to recognize that just because the costs of a program do not register in the federal budget, they may nonetheless represent real costs to society. This statement began with a discussion of how the burdens of the current system are shared. It is critical to recognize that the costs of long-term care are now borne by society but borne in a very uneven way. A publicly provided program would help to spread those costs in a more affordable manner across the population, while assuring all our citizens access to care. An increased public role does not imply that society's costs have risen as well. Alternative solutions, such as mandating employers to offer such care or encouraging private insurance might lower the impact on the federal budget, but society's costs would remain, and the benefits would not be universally available. Thus, in evaluating the desirability of various options, AARP believes that we should consider society's burdens and not just government's costs.

The Association looks forward to working with Congress to find realistic solutions to the long-term care financing problem. We believe Americans are ready to face this challenge to protect current and future generations of families from the devastating costs of illnesses that require long-term care.

Chairman **Stark**. Bill, welcome back to the committee. You may proceed in any manner you are comfortable.

STATEMENT OF WILLIAM DODDS, EXECUTIVE BOARD MEMBER, NATIONAL COUNCIL OF SENIOR CITIZENS, ACCOMPANIED BY ERIC SHULMAN, LEGISLATIVE DIRECTOR

Mr. **Dodds**. I am Bill Dodds, executive board member of the National Council of Senior Citizens. On my left is Eric Shulman, our legislative director.

May I say how deeply we have appreciated your long and most skillful efforts to improve health care for Americans of all ages.

You often speak about your mother, because I read the Congressional Record every day and have for 35 years, and I want to let you know, Mr. Chairman, that my own mother is a bright, active 94-year-old who has been in a long-term health care facility for more than 4 years. She has a great-granddaughter who has had a very serious infant illness—very serious—that required great medical care and assistance.

And what strikes me is two comments my mother has made. One, she has said over and over again, "I am not afraid to meet my maker, but I am afraid to pay my medical bills." Here is a proud woman, 94, not afraid to die, but afraid to live and be ill.

The second thing she says, "Would you please tell your friends and the people in Congress," when she heard I was going to testify, "that I am not only concerned about long-term health care for myself, but for my little great-granddaughter and all the granddaughters across the society."

So I want to say that we are here today to testify not only for ourselves, myself as a grandfather on medicare, but representing the NCSC, we are deeply committed to developing a solution to long-term care that will not only help those of us who are older Americans but, indeed, help the many children and disabled Americans under the age of 65.

I would like to submit my full written testimony for the record and present a shorter summary of it at this time.

We would like to see these elments in long-term health care package. Long-term care should be provided through an entitlement program either within the current medicare program or as an addition to it.

Second, eligibility should be based on need, not on income, and should be extended to the nonelderly population. Financing should be broad based and should not burden the poor.

Financing cannot be restricted to seniors only. As a matter of fact, we are deeply interested in the point you raised about inheritance taxes and other innovative ways to take care of it.

Chairman **Stark**. I have 5 minutes to vote, and I guess my colleagues in the aging process are not as swift as they once were.

I would like to hear your summary and I am going to recess for 4 or 5 minutes, and ask you to pick up and do the summary.

We will recess for 5 minutes.

[Recess.]

Chairman **Stark**. We will resume.

Mr. Dodds. We hope that a long-term care solution passed by Congress will not rely heavily on private long-term care insurance, have an extended waiting period before long-term care benefits begin, have heavy out-of-pocket costs, and put benefits out of the reach of low- and moderate-income elderly.

Plans that propose a 1- or 2-year waiting period before benefits begin suggest that Medicare is available and is an acceptable solution for low- and moderate-income seniors who can't afford private long-term care insurance. But nearly half of all nursing home residents become Medicaid eligible in the first month of their admission, 70 percent of those living alone within 13 weeks.

What these proposals don't recognize is that requiring individuals to become poor before they can receive coverage is part of the problem.

Second, 20 States don't allow nursing home residents to spend down, so if your income is over a certain low level, you can't receive Medicaid coverage no matter how large your medical or long-term care bills. Private long-term care insurance provides incomplete coverage, is expensive, and according to the Brookings projections, would not reduce net medicaid expenditures significantly.

For this reason, we are very glad you have introduced H.R. 5085, a bill to set minimum standards for private long-term care insurance. By introducing this bill, you have shown that consumer protection and welfare is a top priority. Your bill expands and improves on the current National Association of Insurance Commissioners' minimum standards in several important ways.

We propose several additional points for your consideration.

One, long-term-care insurance policies should be standardized or made available through the Federal Government to allow consumers to compare prices and to ensure adequate coverage.

Two, greater emphasis should be placed on enforcement of Federal and State regulations. In the current medigap market, while most States have requirements that meet or even exceed the NAIC model standards, enforcement is seldom a high priority. The Federal Government should have a look behind authority and should impose penalties on both insurers and State governments who are found violating or not enforcing the law.

Three, voluntary Federal certification of medigap policies has been far from successful. Under the Baucus amendments, insurers in States that do not impose the NAIC minimum standards can request a Federal seal of approval for their policies to show consumers that their products at least meet the minimum standards.

According to the GAO, however, not one insurance company has ever made a serious request for Federal certification. One company once made an initial request for certification but didn't follow up. We question, then, the value that Federal certification holds in the market.

Four, requiring policies to meet higher standards may help increase consumers' protection, but will also drive up already high policy prices. Even the best policies would be of no value if people can't afford them.

I hope our testimony will be helpful to you as you go forward with your legislation, and I want to thank you again for giving us this opportunity to provide our comments.

Thank you.

Chairman STARK. Thank you.

[The statement of Mr. Dodds follows:]

STATEMENT OF WILLIAM DODDS, NATIONAL COUNCIL OF SENIOR CITIZENS

Thank you, Mr. Chairman. My name is Bill Dodds. I am an Executive Board Member of the National Council of Senior Citizens, which has been actively advocating issues of importance to the elderly since 1965. I appreciate the opportunity to present testimony to your Subcommittee today on the important issue of long-term care financing.

The long-term care problem currently facing our country is already of crisis proportions and only promises to get worse. It's important to remember that, while long-term care is primarily identified as a problem facing older Americans, 11 percent of all nursing home admissions are for people under age 65. Our members are deeply concerned about the long-term care needs of this population as well.

It isn't enough for politicians, health care professionals, and advocates to say that something must be done. That fact has long since been established. Instead, we need to focus on what specifically should be done to address the problem before us. I applaud your leadership in this area and the resolve you've shown to finding solutions to these difficult problems.

Overview of the Current Situation

The current long-term care system is a national disgrace. It requires Americans to pauperize themselves and their loved ones before it will provide the care they need. It strips our oldest citizens of their dignity. And it forces the disabled of all ages from the comfort of their homes and families. It's a cruel system that extracts far too high a price from individuals, families, and society in general.

America is an aging society. In 1985, about 12 percent of the U.S. population, nearly 30 million individuals, were 65 years old or older. By the year 2020, older Americans will make up more than 17 percent of the total population, about 53 million people. The oldest segment of our aging population--people older than age 85--which is the segment most in need of long-term care, is also the fastest growing segment. By the year 2020, the number of people in this age group will have grown by 250 percent, from 2.9 million in 1985 to 7.1 million in 2020.

Although only five percent of all older Americans are likely to be in a nursing home at any given time, that likelihood increases with age. In 1985, an estimated two out of every 100 persons in the 65 to 74 age group, 7 out of 100 persons in the 75 to 84 age group, and about 16 out of 100 in the 85-plus age group were in a nursing home on any given day. According to the Brookings report on long-term care, as the population ages, the number of older Americans in nursing homes is expected to increase from 2.3 million in 1986-1990 to 4 million in 2016-2020.

In addition to the millions in nursing homes, there are an estimated three million older Americans living at home who also need long-term care. About 70 percent of all long-term care is provided in the home by informal caregivers--primarily wives, daughters, and neighbors. Usually, the cost of this informal care is not included in official estimates of the cost of long-term care.

As important as family care is, the family's ability to contribute is declining. Fewer women are able to permanently leave the workforce in order to provide care at home. And more adult children are living far away from the family home. As the family's share declines, those in need of long-term care will have to rely more on formal sources of long-term care, like institutionalization, which means that the public share of the burden will continue to grow.

In 1985, total expenditures for nursing home care were $35.3 billion. Expenditures in this area are growing at a very rapid rate, due both to increased need for services and high inflation rates. In fact, between 1980 and 1990, expenditures are due to increase by more than 50 percent. The expenditure pie is divided as follows:

Federal and State Medicaid expenditures for nursing home care:

1986: $16.6 billion
42 percent of total national spending
89 percent of total public spending
44 percent of total Medicaid spending

Medicare expenditures for nursing home care:

1986: $585 million
Less than 2 percent of total national spending
3.5 percent of public spending
Less than 1 percent of total Medicare spending

Private long-term care insurance:

1 percent of total national spending

Out-of-pocket expenditures for nursing home care:

1986: $17 billion
55 percent of total national spending

There are more than 80 federal programs that provide some element of long-term care, including meals, health care and social services. This hodgepodge of programs and funding sources manages to provide needed care to millions of older Americans. Medicaid, the national health care program for the poor, has become the defacto long-term care program in this nation. Expenditures for long-term care comprise the fastest growing part of the Medicaid program. Even though the elderly and disabled constitute only 28 percent of Medicaid recipients, they account for 74 percent of Medicaid expenditures. More striking, nursing home residents comprise only seven percent of all Medicaid recipients, but account for 48 percent of all costs.

Most of the elderly on Medicaid were not Medicaid recipients when they entered the nursing home. Rather, they spent-down, most within 13 weeks of admission, by paying high private pay nursing home rates to the point where their incomes and assets were well below the poverty line, making them eligible for Medicaid.

Reliance on Medicaid as our primary long-term care program has lead to some very unsavory public policy outcomes. Medicaid forces individuals into poverty before granting them needed assistance. The program stresses institutional care, to the neglect of more desirable and less expensive home care. And burgeoning expenditures for long-term care necessarily mean fewer Medicaid dollars for needed care for children and families living in poverty.

Discussion of Public v. Private Approaches

Much of the discussion currently surrounding long-term care financing deals with ways to coax the private sector to pick up more of the long-term care tab. Considering the costs of long-term care financing, especially comprehensive long-term care that would include both nursing home and noninstitutional care, it's easy to understand the eagerness to find private sector solutions. These approaches need to be analyzed carefully according to how realistic expectations are that they can become viable options and who would most benefit under each option.

Private Long-Term Care Insurance

Private long-term care insurance seems to be one of the most talked about approaches to solving the long-term care problem. The popular theory is that the need for long-term care is an insurable event, like having your house burn down, and so a reasonable person should be willing to insure himself against it.

I think the public, however, is getting an undeservedly bad name for its reluctance to purchase private long-term care insurance. For a number of reasons, the public's unwillingness to buy long-term care insurance is very rational. First, most private policies cover only nursing home care. Although the likelihood of needing nursing home care increases with age, only five percent of all seniors are in nursing homes at any given time. Seventy percent of needed care is provided while the individual still lives at home. Most seniors never need nursing home care.

Along with a low likelihood of needing nursing home care, seniors absolutely dread the idea of having to be placed in a nursing home. It's something that most people would rather not plan for and feel they will avoid at all costs.

Even in terms of dollars and cents, it's reasonable that people would be reluctant to buy long-term care policies. Policies are very expensive for seniors to purchase, since the price skyrockets as the risk increases. So seniors most able to buy policies are also those most able to pay private pay rates. And as the Brookings study shows, inflation in nursing home care is so high that, even if an individual were to purchase a plan at the age of 30, it would provide little coverage by the time it was needed.

Some analysts are concerned that the existence of private long-term care insurance would induce demand for nursing home care. On the contrary, price, not demand, would increase as nursing homes looked for ways to increase their net incomes by drawing on private insurance reimbursement. Those who believe that demand for nursing home care would skyrocket as a result of private insurance being available to cover the costs of care are forgetting an important truth about nursing home care.

Interviews with adult children who have had to place a parent in a nursing home make clear the guilt and pain that accompanies this event. Seniors themselves often tell their children and their spouses that they would rather die at home than enter a nursing home. Nursing home placement usually occurs when all other avenues have been completely exhausted and no other options exist. In the vast majority of cases, living in a nursing home is not a comfortable and pleasant experience. Instead, it is a dreaded event in both the individual's and the family's lives.

Knowing this, it's hard to believe that seniors and their families would more actively seek nursing home placement just because they were covered for the cost of care. Even today, when little or no private insurance exists for nursing home care, most homes have long waiting lines for entry despite the high cost of care. It isn't the cost of care, but the need for care that drives nursing home demand.

Nursing home discrimination against Medicaid-eligible residents may become much worse if private long-term care insurance becomes a major part of the long-term care financing picture. Already, low-income seniors as well as those of moderate incomes who will likely spend-down to Medicaid have difficulty finding nursing home placements because of low Medicaid reimbursement rates. Private long-term care insurance will only exacerbate a two-tier system of haves and have-nots in long-term care.

The Brookings report shows little realistic expectations for the possibility of long-term care insurance picking up a significant part of the financing burden. Those that it would help are those with higher incomes. Individuals most in need of financial help, the poor and middle income, would still be left unprotected from the costs of long-term care. In fact, even with

25 percent of the elderly purchasing private long-term care insurance under the Brookings model, the number of nursing home residents dependent on Medicaid would drop by less than 1.5 percent. Similarly, private long-term care insurance would do little to ease Medicare and Medicaid burdens. The Brookings Institute shows no change in Medicare expenditures as a result of private long-term care insurance--not surprising since Medicare currently offers such limited nursing home coverage. But while long-term care insurance may reduce Medicaid expenditures by as much as 18 percent, Medicaid expenditures would still roughly triple by the year 2020. The primary beneficiary of private long-term care insurance, then, would not be individuals, state, or federal governments. Instead, it would be the nursing home industry, giving it access to a larger stream of private pay dollars and weaning the industry of reliance on low Medicaid rates.

Specifically, our concerns regarding private long-term care insurance include the following:

1) Medicaid discrimination must be actively prohibited to ensure that nursing homes do not deny access to low- and moderate-income elderly by accepting only residents whose care will be reimbursed at high private rates.

2) Medicare has proven to be a much better bargain than private insurance by returning 97 percent of receipts in benefits. Private Medigap policies return only 60 percent, often less, due to insurers' profits and the costs of administration, marketing, and advertising.

3) Private long-term care insurance policies, even with many coverage restrictions, are expensive. This restricts affordability and participation.

4) Making long-term care policies better, i.e., requiring that they offer more complete coverage, is a double-edged sword. On the one hand, consumers would have useful policies to choose from, but on the other hand, the policies would be even more expensive and out of the reach of the majority of seniors.

5) Private insurance is regressively financed since premiums are the same for people of all income levels. A public program could avoid this problem.

Federal Stop-Gap Approach

A federal stop-gap approach would provide federal payment for nursing home care only after an initial waiting period, usually a year or two. The idea behind this approach is that private efforts should pick up the costs for the initial time period, with the federal government picking up the costs only after private efforts are exhausted.

This approach assumes either that individuals can cover the costs of the waiting period or that private insurance will fill in the gap. However, most individuals are impoverished after 13 weeks in a nursing home--long before the waiting period in most proposals is up. And the possibility of private long-term care insurance becoming viable enough to fill the gap is small.

The primary beneficiary of this approach, then, would not be individuals, but insurers. Private insurers seem to be most concerned about insuring the tail-end risk of nursing home care--care of individuals who remain in nursing homes for much longer than the norm. The federal government, under a stop-gap approach, would guarantee private insurers limited risk.

Individual Medical Accounts

Individual medical accounts (IMAs) are another approach to enabling the private sector to pay more of the long-term care bill. Like individual retirement accounts (IRAs), the idea is to encourage individuals to save throughout their working lives so that funds are available after they retire. Unlike IRAs, IMA funds could be used only for long-term care or other health care needs.

Realistically, IMAs have little chance of becoming a viable way of financing long-term care. The experience of IRAs shows that only a small proportion of the population takes advantage of them and these individuals tend to be wealthier and better able to afford the costs of long-term care. It seems unrealistic that people would be more likely to save into a fund which restricts the future use of their savings to certain purposes than one that allows use to whatever is deemed important in the retirement years.

Other Private Approaches

Home equity conversions and continuing care retirement communities are two other private financing approaches.

Home equity conversions draw on the fact that the home is the largest asset owned by most seniors. Under these plans, individuals can sell their home to a bank or mortgage company and are allowed to continue living there while receiving regular payments from the bank. Despite the fact that these conversions have been available for some time now, few seniors have taken advantage of them. Many seniors are very reluctant to sell their homes for any reason.

Continuing care retirement communities (CCRCs) provide a full range of care and living amenities to seniors who reside in the community. Generally, CCRCs require a very hefty entrance fee plus additional monthly payments, and so appeal primarily to high-income individuals. Because of their cost and the fact that seniors must move from their homes, CCRCs are of limited appeal.

Private Approaches Generally

Generally, the potential for private approaches to absorb a major portion of the long-term care financing problem seems very limited. Most private approaches are regressive in their financing, are within the reach of only a few, and some seem to benefit insurers and the nursing home industry more than individuals who need long-term care. There is also a real danger that private approaches would erode the nation's willingness or ability to provide care for the less fortunate. Those with higher incomes may come to feel that they are paying their own way and are not obligated to help the less able.

Recommendations

The National Council of Senior Citizens believes the elements of long-term care financing reform include:

Eligibility:	Long-term care should be provided through an entitlement program either within the current Medicare program, or as an addition to it. Eligibility should be based on need, not income, and should be extended to the non-elderly population as well.
Financing:	Financing should be broad-based and should not overly burden the poor. Financing cannot be restricted to seniors only, as in the recently-enacted catastrophic health care bill. Long-term care financing is simply too great a burden for any one group to bear. And long-term care coverage would help all generations.

Benefits: Care should be provided that is appropriate to one's need. Not only nursing home care, but also home health and adult day care should be important components of the spectrum of care. And care must be of high quality, wherever the care is provided and whatever the funding source.

In addition, there are several items we hope a long-term care solution will not include:

1) heavy reliance on private long-term care insurance or individual medical accounts (IMAs);

2) an extended waiting period (1-2 years) before long-term care benefits begin;

3) heavy out-of-pocket health care costs in addition to those already borne by seniors; and

4) benefits which low- and moderate-income seniors cannot reach and financing that overburdens them.

One of the most serious problems with proposals that require long waiting periods before benefits begin is that they hold no promise for most older Americans. According to the 1985 Nursing Home Survey, nearly half of all elderly nursing home residents are Medicaid eligible in the first month of admission. In addition, a 1985 study done by the House Select Committee on Aging showed that, for the elderly living alone, 70 percent of those aged 65 and over risk impoverishment after 13 weeks in a nursing home.

Relying on Medicaid and the spend-down process to act as a safety net for this population misses the fact that tying eligibility for care to poverty is one of the problems that needs to be solved. It also ignores the fact that twenty states (see table attached) do not allow residents to spend-down to the Medicaid eligibility level. These states set an upper limit on incomes, above which an individual is not eligible for Medicaid services. The income ceilings in these states are at or below 300 percent of the SSI eligibility level and range from a low of $632 a month (Delaware) to $1,020 a month. This means that no matter how high a person's medical or long-term care expenses are, if his income is even slightly above that amount, he cannot qualify for Medicaid benefits. Individuals in these states are often in the position of being "wealthy" for Medicaid, but too poor to pay their long-term care bills or afford private long-term care insurance. To address this problem, all states should be required to allow residents to spend-down.

NCSC Position on H.R. 5085, Legislation to Provide Standards for Private Long-Term Care Insurance

The National Council of Senior Citizens does not advocate private long-term care insurance as a source of long-term care coverage. However, important consumer protections must accompany any growth in private long-term care insurance. The Medigap area is infamous for the extent of consumer fraud and abuse that proliferates there. Consumers are sold worthless, multiple, and unnecessary policies, and are subject to misrepresentation, coercion, and intimidation.

The potential for these abuses in the private long-term insurance market is especially great. Congress should ensure strong consumer protections to guard against these abuses before they become widespread. We are very encouraged by your recognition of this need and by the fact that you've given consumer protection the high priority it deserves.

H.R. 5085 makes some very important improvements on the National Association of Insurance Commisioners' (NAIC) model standards. Your bill prohibits requirements of prior hospitalization or prior provisions of higher levels of care. It also prohibits insurance companies from only paying for care, or significantly more care, in a skilled nursing facility than at lower levels. The bill further requires that each policy carry the telephone number of the insurance commissioner in the state in which it's issued and requires the Secretary of HHS to provide important information to beneficiaries on long-term care policies and coverage.

We propose several additional points for your consideration.

1) Long-term care insurance policies should be standardized or made available through the federal government to allow consumers to compare prices and to ensure adequate coverage.

2) Greater emphasis should be placed on enforcement of federal and state regulations. In the current Medigap market, while most states have requirements that meet or even exceed the NAIC model standards, enforcement is seldom a high priority. The federal government should have look-behind authority and should impose penalties on both insurers and state governments who are found violating or not enforcing the law.

3) Voluntary federal certification of Medigap policies has been far from successful. Under the Baucus amendments, insurers in states that do not impose NAIC minimum standards can request a federal "seal of approval" for their policies to show consumers that their products at least meet the standards. According to the GAO, however, not one insurance company has ever made a serious request for federal certification. One company once made an initial request for certification, but, didn't follow up. I question, then, the value that federal certification holds in the market.

4) Requiring policies to meet higher standards may help increase consumers protection, but will also drive up already high policy prices. Even the best policies would be of no value if people can't afford them.

Conclusion

The unmet need for protection form the costs of long-term care poses a very serious threat to this nation. It's a problem that affects all generations, all income levels, and all segments of the country. The sooner we deal with it, the more controllable the solution will be.

Finding a way to more equitably spread the costs for what has become a societal problem will not only help us economically, but will help restore dignity, predictability, and protection for Americans in the later years of life.

Thank you again, Mr. Chairman, for the opportunity to address the issue of long-term care financing and to represent our members before your Subcommittee.

TABLE 3: Limits on Monthly Income for Aged Individuals Seeking Medicaid Coverage of Nursing Home Care

	A No Fixed Upper Limit	B Patients With Incomes In Excess of [Dollar Amount] Are Not Eligible For Medicaid Coverage Of:		
		Nursing Home Care (Only)	Any Medicaid Services	Limit Applies to ____ Income
Alabama	—	—	$ 852.80	Gross
Alaska	—	—	1,020.—	Gross
Arkansas	—	$ 1,020.—	—	Gross
California	NO LIMIT	—	—	—
Colorado	—	—	1,020.—	Gross
Connecticut	NO LIMIT	—	—	—
Delaware	—	—	832.—	Gross
D.C.	NO LIMIT	—	—	—
Florida	—	881.—	—	Net
Georgia	—	—	937.—	Net
Hawaii	NO LIMIT	—	—	—
Idaho	—	—	1,020.—	Gross
Illinois	NO LIMIT	—	—	—
Indiana	NO LIMIT	—	—	—
Iowa	—	1,020.—	—	Gross
Kansas	NO LIMIT	—	—	—
Kentucky	NO LIMIT	—	—	—
Louisiana	—	1,020.—	—	Gross
Maine	NO LIMIT	—	—	—
Maryland	NO LIMIT	—	—	—
Massachusetts	NO LIMIT	—	—	—
Michigan	NO LIMIT	—	—	—
Minnesota	NO LIMIT	—	—	—
Mississippi	—	—	1,020.—	Gross
Missouri	NO LIMIT	—	—	—
Montana	NO LIMIT	—	—	—
Nebraska	NO LIMIT	—	—	—
Nevada	—	—	734.—	Gross
New Hampshire	NO LIMIT	—	—	—
New Jersey	—	—	1,020.—	Gross
New Mexico	—	—	871.—	Gross
New York	NO LIMIT	—	—	—
North Carolina	NO LIMIT	—	—	—
North Dakota	NO LIMIT	—	—	—
Ohio	NO LIMIT	—	—	—
Oklahoma	—	1,020.—	—	Gross
Oregon	NO LIMIT	—	—	—
Pennsylvania	NO LIMIT	—	—	—
Rhode Island	NO LIMIT	—	—	—
South Carolina	—	—	1,020.—	Gross
South Dakota	—	—	1,020.—	Gross
Tennessee	—	1,020.—	—	Gross
Texas	—	—	658.65	Gross
Utah	NO LIMIT	—	—	—
Vermont	NO LIMIT	—	—	—
Virginia	NO LIMIT	—	—	—
Washington	NO LIMIT	—	—	—
West Virginia	NO LIMIT	—	—	—
Wisconsin	NO LIMIT	—	—	—
Wyoming	—	—	1,020.—	Gross

Policies and standards in effect as of the second quarter of 1987 (effective July 1, 1987 or earlier).
The accompanying legend and notes are an integral part of this table.

— means "not applicable."

Source: National Governors' Association, Health Policy Studies.

A: States that allow residents to "spend-down" to Medicaid eligibility levels.
B: States that do not allow residents to "spend-down."

Chairman STARK. Our next witness will be Martha McSteen.

STATEMENT OF MARTHA McSTEEN, SENIOR LEGISLATIVE COUNSEL, NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

Ms. McSTEEN. Mr. Chairman, I am Martha McSteen, one of the first 10 regional representatives for the Medicare program. Today, I am sincerely pleased to appear before you on behalf of the National Committee's 5 million members whom we do endeavor to represent.

Mr. Chairman, the National Committee commends you for holding these hearings on the most serious problem facing seniors today, the catastrophic cost of long-term illness. The National Committee endorses the expansion of Medicare insurance to cover long-term care.

We would hope that such expansion would provide a comprehensive coverage which includes nursing home care as well as noninstitutional care.

The National Committee also believes that there is an important role for the expansion of private insurance to supplement medicare but that a public plan is needed as a foundation.

We are encouraged that you are also responding to the need for minimum standards for long-term care, private insurance policies. We hope long-term care legislation will receive prompt and positive attention from your colleagues.

The many letters from the National Committee members clearly depict a crying need for long-term care protection. While most individuals think of long-term care in terms of nursing homes, support for noninstitutional services is equally important. Home care, day care and respite care can prevent premature institutionalization with its higher cost and potentially lower quality of life.

The just passed catastrophic health care legislation already includes a modest respite care benefit which could be expanded and Mr. Pepper's bill, H.R. 3436, is a good model for long-term home care.

For most beneficiaries, as it has been said this morning, nursing home care at $25,000 a year is prohibitively expensive. If there is a waiting period before the nursing home coverage by medicare begins, it should be no longer than a year.

Care management is the key to both coordinating long-term care benefits and controlling costs. An effective care management system serves as a great way to assure that only needed services are provided and that beneficiaries do not experience gaps in service.

In addition to coverage for seniors and disabled, the National Committee recommends including children in your long-term care program. Doing so would follow the general principle that Social Security and Medicare insure workers and their families for risk against which the private sector does not protect.

The need for long-term care is not age-related, so excluding children from coverage would undermine the political support for the broad-based financing which is needed to finance long-term care. Neither the public or private sector alone can provide adequate long-term care. The private sector has been cautious entering the long-term care insurance market because of the unlimited risk.

That is why Medicare, long-term care insurance is needed as a foundation, although a successful long-term care public policy depends on insurance companies offering affordable policies to cover the deductibles and copayments not covered by medicare. If the deductibles and copayments are too big, private insurance policies would not be affordable.

The National Committee would support tax incentives to stimulate development of long-term care policies as long as they are linked to minimum standards to protect the consumer against poor products and unscrupulous practices.

We encourage you to mount a mass media information drive to improve the understanding of just what long-term are needs are, what financial protection is available and what the costs are. Only through such a massive effort will seniors and their families come to understand how to protect themselves against the dreaded cost of long-term care.

Mr. Chairman, the National Committee urges you to propose long-term care insurance with broad-based financing consistent with social insurance principles. Any long-term care legislation with adequate coverage will have a large price tag, but a political consensus is developing which will accept the necessary taxes especially the elimination of the wage-based cap on the Medicare portion of the payroll tax.

Congressman Pepper has told us that Chairman Rostenkowski has pledged to dedicate revenues from lifting the wage base to long-term care, and we welcome that approach. The public recognizes that a public insurance program would replace private spending and relieve families of the emotional and financial stress.

We are ready to work with you and your staff to develop this important legislation. America's seniors are counting on you to provide the leadership to find a way to meet the needs for long-term care insurance.

Thank you.

Chairman STARK. Thank you.

[The statement of Ms. McSteen follows:]

NATIONAL COMMITTEE TO PRESERVE
SOCIAL SECURITY AND MEDICARE

2000 K Street, N.W., Suite 800, Washington, D.C. 20006 (202) 822-9459

Mr. Chairman, I am Martha McSteen, and I was one of the first ten Regional Administrators for the Medicare Program. My long career in Social Security and Medicare culminated in 1986 when I concluded a nearly three-year term as the Acting Commissioner of the Social Security Administration. Today, I am pleased to appear before you on behalf of the National Committee to Preserve Social Security and Medicare and its five million members and supporters. During the debate on catastrophic care, our members frequently wrote about the devastating impact of long-term illness and the flaws in our health care system. Mr. Chairman, on behalf of the members of the National Committee, I commend you for holding hearings on the most serious problem that faces seniors today - the catastrophic cost of a long-term illness.

> **The National Committee endorses the expansion of Medicare insurance to cover long-term care. We hope that such expansion would provide comprehensive coverage which includes nursing home care as well as non-institutional care such as home care, day care and respite care. The National Committee also believes that there is an important role for the expansion of private insurance to supplement Medicare, but that a public plan is needed as a foundation. We are encouraged that you are also responding to the need for minimum standards, preferably requiring them, for long-term care private insurance policies.**

NEED FOR LONG-TERM CARE

We hope long-term care legislation will receive prompt and positive attention from your colleagues in Congress. The sooner this coverage becomes a reality, the sooner people such as 84-year old Carrie Moore of Rome, Georgia, and her 86-year-old sister who suffers from Alzheimer's disease will receive help. Ms. Moore writes: "More than two years ago I took (my sister) into my home to protect her from the severe winter weather. . . She must not be alone more than ten minutes - doctor's orders. She has to be bathed, dresssed and led to bed. Often I am awake all night and sleep only while she naps a bit during the day. On February 23, as I rushed to complete the early morning chores, I fell and cracked an ankle bone. . . I must pay a volunteer to live in and care for us. The drain on my dwindling savings seems awful; but what can I do? We can adjust to a handful of crackers and a glass of milk for a meal; but medicine doesn't come cheap."

Michael DeLoia from Hopedale, Massachusetts, desperately needs help caring for his 69-year-old wife. He writes: "The stroke blew a hole in her brain the size of a quarter, but after six months in a nursing home I had her brought home. I gave up my salesman's job just to care and watch over her; now I have been caring for her for 12 years. I had Medicare, but that wasn't enough and I spent all my life's savings to do all I could to help her recover. . . I need help to care for her. We live on a Social Security pension."

The last example emphasizes that the problem affects the whole family. Despite the willingness of family members to care for loved ones, the problem is overwhelming. A member wrote her Florida Senator: "We know first hand what a tragedy long-term illness can be, as a close (73-year-old) family member has Alzheimer's Disease. Round-the-clock nursing care at home has been required for several years; and further deterioration now requires full-time care in a nursing facility. There is no end in sight. The emotional strain alone is intolerable, but when the financial burden is added, the situation becomes unbearable."

BENEFITS

Non-Institutional Care

While most individuals think of long-term care in terms of nursing homes, support for non-institutional services is equally important. Home care, day care and respite care can prevent premature institutionalization with its higher costs and potentially lower quality of life. The just-passed catastrophic health care legislation already includes a modest respite care benefit which could be expanded and Congressman Pepper's H.R. 3436 is a good model for long-term home care.

Whatever services finally will be covered in your proposal, families should be allowed to supplement benefits with their own resources in cases where the dependent senior needs more care than permitted under Medicare. The current Medicare home health benefit does not allow private supplementation.

Adult day care benefits should be covered by Medicare when it has been determined that such a facility could provide the right level of care for the disabled senior. Adult day care is becoming an important part of the long-term care system in this country. The typical adult day care client is well enough to live in the community, but requires assistance with one or more activities of daily living. Going to a day care facility provides a stimulating atmosphere for the senior while it enhances the family's ability to carry on normal activities of work and family life. More important, it often postpones the time when a senior has to enter a nursing home.

The National Committee also recommends that respite care be included in your proposal. Respite care, whether it is care in the home, in a day care facility or a brief stay in a nursing home facility, is vital for those helping seniors live at home. Relief from caregiving duties should be available to all primary caregivers including those who do not live with the disabled person. The 1982 Informal Caregiver Survey of the National Long-Term Care Survey found that 26 percent of the 2.2 million caregivers in this country did not live with the disabled person. Yet, we know it can be just as exhausting for a caregiver to run between his or her own home and the home of the disabled person several times a day to make sure that adequate care is provided.

This situation was powerfully illustrated in a nationwide video teleconference earlier this year entitled "Aging in America: Dignity or Despair." At 250 sites across the country, 50,000 people watched a documentary of a young woman who spends all her waking hours away from her own family taking care of her father in his home. At night, after a long day at work, her brother relieves her so that she can go home to her young children and husband. This family would greatly benefit from respite care.

Nursing home care

The most costly form of long-term care is nursing home care. Well-publicized studies released by the House Select Committee on Aging found that almost half of couples with one spouse in a nursing home sink into poverty within 13 weeks and around 80 percent of couples do so within one year. About 70 percent of individuals hit poverty within 13 weeks of a nursing home stay and more than 95 percent of singles go broke within one year. If there must be a waiting period before nursing home coverage by Medicare begins, it should be no longer than a year.

Care Management

Care management is the key to both coordinating long-term care benefits and controlling costs. An effective care management system serves as a "gateway" to assure that only needed services are provided and that beneficiaries do not experience gaps in services. Also, if an individual has no insurance and cannot afford to pay for long-term care, the care manager can assist in applying for Medicaid or identifying other services or resources.

Cost control and the wish to limit potential conflicts of interest dictate separating direct service providers from care managers. However, the National Committee suggests that eligibility review and care management be integrated and not set up as two completely separate structures. Two structures not only would require seniors to face two layers of bureaucracy, but also would create an artificial division between the assessment of an individual's eligibility and the development and management of a care plan based on that assessment. The assessment and the development of a care plan should be done at the same time. Another important benefit of combining eligibility determination and care management is that the eligibility decision would be based upon a face-to-face multidisciplinary assessment rather than upon a paper review.

The National Committee also recommends that beneficiaries begin to receive care management as soon as the potential need for long-term care services is identified, even during the acute care stage. The need for care management should be identified as part of the hospital discharge process. Care management should integrate current Medicare benefits for acute care with the new long-term care benefits to eliminate gaps in coverage.

Another, more financial, reason for initiating care management and determining eligibility early in the process, is to establish that out-of-pocket long-term care costs would be Medicare-approved and apply towards deductibles and would be covered by private insurance.

Eligibility

The National Committee recommends basing eligibility primarily on having deficiencies in two or more activities of daily living (ADL), or suffering significant cognitive deficiencies. Clearly, many individuals in the early and middle stages of Alzheimer's disease would not meet the eligibility on the ADL criteria alone, yet their families are in real need of assistance. Studies of families with dementia patients indicate that the families' perceptions of their burden decreased over a two year span, even though the disease progressed and the patients' problems occurred as often as before. Long-term care legislation should allow families to get respite during the early stages when they are most subject to severe stress.

It is estimated that between 100,000 and 200,000 children are in need of long-term catastrophic care. Therefore, the National Committee recommends including children in your long-term care proposal. Doing so would continue the general principle that Social Security and Medicare insure workers and their families against risks for which the private sector does not provide protection. The need for long-term care is not limited to seniors, so excluding children from coverage would undermine the political support for the broad-based financing which is needed to finance long-term care.

INTEGRATION WITH PRIVATE INSURANCE

Neither the public nor private sector alone can provide adequate long-term care. A successful long-term care public policy requires that insurance companies offer affordable policies to cover the deductibles and copayments not covered by Medicare. If the deductibles and copayments are too big, private insurance policies will not be affordable. Ideally 85 to 90 percent of seniors who are above the poverty line should be able to afford private insurance.

The National Committee would support tax incentives to stimulate the development of long-term care policies as long as tax incentives were linked to minimum standards to protect the consumer against poor products and unscrupulous practices.

A recent Consumer Reports analysis of 53 long-term care policies pointed out serious flaws in most of the products currently offered on the market. Many policies have no inflation adjustment on benefits, a failure which makes such policies almost worthless for individuals under age 60 who do not expect to need long-term care for years to come. Another problem is the exclusion of Alzheimer victims in many policies. The requirement that coverage in a nursing home has to be preceeded by a hospital stay eliminates most dementia patients as well as other patients suffering chronic conditions not requiring acute attention. Fortunately, some states have banned the prior hospitalization feature.

The National Committee would encourage you to direct a mass media informational drive to improve the understanding of just what long-term care needs are, what financial protection is available and what the costs are. Only through such a massive effort will seniors come to understand how to protect themselves against the dreaded cost of long-term care.

FINANCING

Mr. Chairman, the National Committee urges you to propose long-term care insurance with broad-based financing consistent with social insurance principles. Expanding on the "user fee" approach of the catastrophic legislation would be a mistake.

Any long-term care legislation with adequate coverage will have a large price tag, but a political consensus is developing which will accept the necessary taxes, especially the elimination of the wage base cap on the Medicare portion of the payroll tax. We welcome Chairman Rostenkowski's pledge to Congressman Pepper to dedicate revenues from lifting the wage base to long-term care. The public recognizes that a public insurance program would replace private spending and relieve families of the emotional and financial stress.

The National Committee supports in principle the idea that seniors should contribute to part of the cost of expanded Medicare coverage, up to 25 percent of the cost. But with the new catastrophic health insurance legislation charging 100 percent of the cost to seniors, the National Committee would not support any further increase in Medicare premiums to pay for long-term care.

Conclusion

Mr. Chairman, we are prepared to work with you and your staff to develop this important legislation that would finally extend long-overdue true catastrophic protection against the cost of long-term care. America's seniors are counting on your leadership to find a way to meet the needs for long-term care insurance.

Chairman **Stark**. Let me see if I can outline for you the problem you present the committee. Yesterday I met with a legislator who is vitally involved in health legislation, who told me that he had revised Senator Mitchell's bill which does approach all of the benefits.

This particular Member of Congress had done a more sophisticated job, in his own words, in providing these benefits, and I asked him how much it would cost. And he said it would cost about $50 billion a year.

I think we have heard testimony this morning to that effect. I think $50 billion just for purposes here of choosing a little is a good number. I, like most of you, think that we should include others, because I think it is fair. I don't want to get into the intergenerational battles, so, say if we required all employers to provide insurance and make it budget neutral, I am not sure we could get it passed. However, I would have to ask your organizations to support us. Take $25 million out of the uninsured and that leaves $10 million uninsured which might cost $20 billion a year to provide prenatal care, et cetera, and I get quickly to about $70 billion.

If we took the cap off of all payroll taxes, I guess we would raise about $30 billion, but if we did the inheritance tax thing at 5 percent, I guess we would raise $5 billion. So even if we went to 10 percent where the screams would get loud, we would raise $10 billion.

I am trying to suggest—I am only halfway there. I don't know, and I am hoping to find out if perhaps raising the lowest bracket of income tax would be from 15 to 16 percent, we still have on the horizon the fact that we are $40 billion short in overall deficit financing of this Government, which the next administration, I am sure, is going to promise to cure, whomever is elected.

So I think what I have to ask each of you is, are you and your organization willing to pitch in with us, because the benefits are easy. We can get unanimous consent on this committee to provide all the benefits everybody is asking for, and we can add a few of our own that you all haven't dreamed up yet.

We had 15 Members on Tuesday tell us how we could improve those benefits. I don't recall one Member who told us how to raise the money. They all told us who we shouldn't raise it from. We shouldn't raise it from the seniors or the taxpayers or from a whole host of people. The tough part is going to be finding that $30 to $50 to $70 billion. And all of you, I know, recall when we did the Social Security bill under the distinguished leadership of Congressman Pickle.

Chairman **Stark**. We made a statement then that if anybody in this town was smiling, the bill was no good. Because that meant we had Federal employees and Members of Congress and the seniors grumped. And I would ask each of you what would happen among your organizations if one of the pieces of this was to raise the taxability of Social Security benefits from 50 to 80 percent, which might actually have to be part of a package.

That could be a difficult pill; right, Ms. Burgess?

Ms. **Burgess**. Right.

Chairman **Stark**. But what I am going to suggest to you is that this may be the kind of support we need from you, part of a package. After we have raised the income tax rate and inheritance tax and taken the cap off of all payroll taxes; if we are short, we may have to come back to something like that.

So, I would ask you in order, please, would your groups all be willing to work with us when the final crunch comes to take on some of these unpopular positions with us to raise the money to pay for these benefits?

How about the Committee To Preserve Social Security?

Ms. McSteen. One reason I said something about the need for a mass media informational survey of some kind is that I think that public sentiment must be aroused more before we can really say what the seniors are willing and able to support. I really feel that throughout this country, many, many people, not just seniors, do not understand what their coverage in medicare alone covers or what other policies cover.

I think once they could see the projected cost of the nursing home care and realize that the recently passed catastrophic bill does not cover nursing home care, but they are paying additional costs, they would be more willing to listen and be more concerned about financing a package that won't be—that will be palatable to the general public.

And certainly we would be glad to work with the committee in any possible way and try to elicit from our members how they feel about certain aspects of the program, as well as the financing.

Chairman Stark. Thank you.

How about Ms. Burgess, what do you think the reaction from your group would be?

Ms. Burgess. Chairman Stark, I am sure you are aware at this stage our policy is not to do that with Social Security. However, we also strongly support the health care initiatives you have mentioned. We realize that the financing is a sticky wicket here, and we are certainly in favor of looking at a variety of kinds of ways of financing long-term care and health care for the uninsured.

I feel sure that we would want to work very closely with you in seeing what we could do to pull together the necessary financing because our members are very much want these new benefits. But I am sure you know that at this stage, our policy has not been to increase taxation of Social Security.

Chairman Stark. I have the numbers now, so if we want to think about it, stated differently, raising the low bracket from 15 to 15.75 percent and raising the high bracket from 28 to 29.4 percent, a 5-percent surtax would raise about $20 billion a year.

So, if you take the $10 or $15 billion that we have now, we still come up short just for the $50 billion that we are talking about that would really be comprehensive. And I think the more we can focus on that among our organizations and as to how we are going to do this, the more quickly we will be able to get to a bill that will satisfy you.

Bill, what would you like to add?

Mr. Dodds. I think, first of all, that I think people forget that people my age and older came out of the depression era. I was raised by a grandmother that when she buttered bread for me, she would put it on like this, and then like this, and then like that. You couldn't hardly see the butter. We were raised to pay our way.

We didn't—I didn't have a credit card until I was over 30-something years old, and to live off the cuff is not our way.

We expect to have to pay our fair share, and I think that one of the weird things that bothers me is that we have a society in which all kinds of effort has been made to say, oh, buy now and pay later. Huge things. Don't worry about it, put it on the credit card. We don't think you can put health care on the credit card or Social Security. We think we have to pay the fair share.

But it would be far wiser to have a genuine progressive based income tax in this country that would tackle the total problem of health care than to do it piecemeal, and in addition, I am worried about what Congressman Donnelly raised.

My mother is in a health care facility, long-term facility where it is understood that members of the family and neighbors will pitch in. It is not just included on some kind of an economic basis. You are expected, because you care about it and it is a cooperative effort, that you keep this idea of some family care being given as well as the economics.

It seems to me, Mr. Chairman, that it is not enough even to examine the economic base. His point is a very good point, which is a tough one to wrestle with. But if we can't get the kind of society that continues to care about continuing care for our great granddaughter and my mother at 94, we are in more difficulty than I think.

And I think it has to be both things going there.

Chairman **Stark**. I agree, and I think you have hit on the point. I think if we can just get the public's awareness that this is a problem, that it isn't just something that is going to fall out of the sky and be provided. But I don't think the public has the awareness. Just look at the Medicare Catastrophic Coverage Act, which is, I suppose, a meager $7 or $10 billion a year.

You would think that we were an elephant that just ate a mouse. It isn't even very big. We are talking here about something seven or eight times as big as that, and I think we have to prepare the public and our constituents and our colleagues who say to me on the floor, why don't you take care of this? Well, we are now hearing testimony which outlines some of the problems that we will be faced with.

Mr. Coyne. Mr. Donnelly.

Mr. **Shulman**. If I can, I would point out that we face a different situation in terms of the coverage of long-term care, in terms of the willingness of older people to pay their fair portion of the overall freight.

To some extent, I think older people feel much more exposure on the long-term care side than they do in terms of catastrophic acute care.

Chairman **Stark**. I would differ. Some 70 to 80 percent of the seniors with Medicare buy some kind of medigap policy. And they don't buy that because they like Danny Thomas or Lorne Greene. They buy it because they are scared. Because they have the medigap policies, they wonder what they are getting with the catastrophic benefits. This is really nothing more than a Federal medigap policy, which is a little better, I think, than what is in the market, but we will see in time.

The idea that the only person who benefits is the person who gets sick is wrong. Everyone concerned benefits because the real benefit is peace of mind. God pray that no one needs to use the catastrophic benefits. However, I think there is an equal fear. It just depends on what the press and the anecdotal horror stories that you are hearing are.

We do have some, you know, there have been a lot of cases. I would suggest that in recent years, the issue of Alzheimer's disease, which probably has been with us a while, but which people are just learning more about, is probably increasing some of the fear.

Also cancer, which people have known about for a long time, and heart transplants which everyone knows are quite expensive.

Mr. SHULMAN. It is hard to know of. I am speaking for our own members that catastrophic acute care protection, while it may be important for some, was by and large not the type of thing that some of our members were willing to pay the full freight on.

On balance, most of our members won't be paying much for the catastrophic bill at all. But I believe they will be more inclined toward paying a fair share of the long-term care package.

Chairman STARK. I also suspect, with all due respect for your organization, that more of your members had good retiree health benefits than the general public. So perhaps as a class, they won't get as much out of catastrophic protection, especially since they will not have the nursing home and home health care benefits as a part of their benefits.

Mr. DODDS. I wish Mr. Daub was here, because he raised the question, the fact that the private sector should be involved in this. That is great, except that I went on strike for 101 days with Chrysler Motor Co. in order to get a private pension.

Finally, we did. I spent 8½ years on another picket line. And of course, Mr. Califano thinks and says that we now pay over $550 million a year for private health costs and reminds us if we had something like the Canadian approach we would save at least $178 billion of that because of the different approach to it.

That seems to me what we need to get at. But we had to fight every inch of the way to get it. It didn't just drop out of the kindness and sweetness of their heart. We never saw it.

Chairman STARK. How did you do it in Massachusetts, Mr. Donnelly.

Mr. DONNELLY. We will find out next year, when we have to pay for it. In the last page of your testimony, Mrs. McSteen, you say that the National Committee supports in principle the idea that seniors could contribute up to 25 percent of the cost.

Is there unanimity among the panel about that? That the beneficiaries would be willing to pay. Obviously it makes our task a lot easier if there is a benchmark. Is there some sort of unanimity on that?

Ms. BURGESS. We are saying up to 20 or 30 percent. Nothing definitely, but in that range.

Mr. DONNELLY. Eric or Bill; I am not trying to put you on the spot.

Mr. **Shulman**. It is just too early in the process. I wish we could put a figure on that, but I don't believe we are prepared to do that at this point.

Ms. **Smith**. Let me elaborate a bit on Ms. Burgess' answer. What we have said is that an appropriate beneficiary coinsurance for long-term care coverage might be in the range of 20 to 30 percent. However, if you look at that from the standpoint of how much out-of-pocket expenditure that actually means, it will be in the neighborhood of $7,000 to $8,000 a year, which may in fact be an insurmountable expense for the majority of persons—older women—who need long-term care.

So, an exact figure is a hard one to set at this point in time.

Mr. **Donnelly**. What about the estate tax? We have changed the exemption since 1981 from $150,000 to $600,000 exemption. How do your organizations feel on one of two things? One, the so-called Mitchell approach, which would be the 5 percent flat tax on the estates, or two, reducing the $600,000 exemption to provide financing for a long-term care benefit.

Ms. **McSteen**. We have not actually issued a statement regarding that, because we are trying to look at the total financing package and what it buys. We are open to consideration, of course, of it.

Ms. **Burgess**. As far as the estate tax is concerned, we feel that it is a possible source of some revenues for long-term care. However, we believe that politically, there are some very tough choices there. For instance, curtailing the current unlimited marital deduction would tax widows on receipt of husbands assets. At what point do you tax the home, for instance, which in many cases may be the major asset in an estate? And also, what about small farms and small businesses under the current threshold of $600,000?

So, I think there are some very difficult——

Mr. **Donnelly**. No question to me.

Ms. **Burgess**. But it is one of the things that ought to be looked at.

Mr. **Dodds**. Yes.

Mr. **Donnelly**. The reason I ask that question, and I don't want to beat a dead horse, raising the question of the children's role and responsibility. It seems to me that we cannot craft a program without factoring in the children and the grandchildren's role, one, because it is very human; and two, because it is cost-effective and deals with the reality of the present situation in terms of the elderly's care.

What are the children's roles? I mean, what should they be? How can—there is nobody that you represent that wants to go into a nursing home. I have heard that raised. I think it is the last thing that people want to do is be institutionalized, and the last thing that children want to see is their parents institutionalized.

And it is the last thing the government wants, because it is the most expensive option. But how do we craft a program that affects every senior in the country, without falling into the usual pitfall of not factoring in the human element? Does anyone have any suggestions on that?

I mean, I think children ought to be responsible for their parents, that is where I come from, the old ethnic way I was brought up; in today's mobile society, it is different. But it seems to me that children who do take that responsibility and take on the financial responsibility ought to be rewarded, not punished.

The problem with the Mitchell approach is that children of the beneficiaries of the estate and all children would be treated the same way if we took 5 percent out of the estate. So, the children that bore that responsibility don't receive any reward vis-a-vis those children that just said, "Good luck, Ma."

Mr. DODDS. Mr. Chairman, I thoroughly agree that economically, the children and grandchildren should pitch in and help, because that is what the old folks did for them.

Mr. DONNELLY. The beneficiaries of the parents.

Mr. DODDS. That is correct. I was telling Congressman Moody, the latest figures are that four times more older persons right now are supporting their children than the children are supporting them. Four times as many older persons over 65 are supporting their children than the other way around.

It may be unbelievable to you, but take it from a grandfather that it is true. The second thing I would say is that you can legislate that they should give so much money out of inheritance or whatever else, but you can't legislate, and we have to find other ways, cultural ways of doing this; is a very crucial thing. It is one thing for part of our family to give my 94-year-old mother *x* number of dollars a month.

What she really also needs desperately is some human care and caring. There is no way you can legislate that. That has to be done in another way. I don't have the answer to that.

Ms. BURGESS. May I mention something here? I think we have to continue the informal support system that we have now. A good many families are taking care of elderly people, certainly, and we want that to continue. In my family we have had that experience on both sides, a 92-year-old mother on mine, and now my husband's mother on the other. We can't afford not to have that type of care continue. That is why respite care is so important.

I would like to mention one other thing about insurance. Many of us are middle-income. My husband and I are. We have comfortable pensions and that is about it. We would get along very well, but as you were mentioning, we are also putting through college, our younger granddaughter and that is not easy.

And we are helping the older one, and I think our situation is not unusual. It is one of the reasons why we do not have long-term care insurance. We simply couldn't work it in. And the older we get, the less likely we are to have it. So those are problems, you know, that come along, and we have to face them as they do. But we do help each other, both older and younger.

Ms. MCSTEEN. There should be some recognition certainly, and I think perhaps this is where tax incentives of some sort might come into play in addressing that issue.

Mr. DONNELLY. It is a good social and economic goal. Any additional questions?

If not, thank you very much. We will be visiting over the course of the next 12 months and trying to come to a consensus to put together good legislation.

Mr. DONNELLY. The next panel is the Consumers Union.

Ladies and gentlemen, please step forward. We will begin your testimony in the order that it appears on the witness list. Please proceed. There is a vote going on, so members will be going back and forth. Please proceed.

STATEMENT OF GAIL SHEARER, MANAGER OF POLICY ANALYSIS, CONSUMERS UNION

Ms. **Shearer**. Thank you, Congressman Donnelly.

What I would like to do today is summarize my statement, and then I would like to take a few minutes to walk through the long-term maze.

My testimony today will focus on the performance of the private long-term care insurance market today and under Chairman Stark's proposed program of Federal standards. The key points are as follows:

First, the private long-term care insurance market is not presently meeting consumers' needs and will not do so in the future without substantial government intervention. Second, there are several very good policy options for improving market performance to enable it to meet consumers' needs. The NAIC model regulation, even with Chairman Stark's improvements, does not go far enough.

In May 1988, Consumer Reports published an indepth evaluation of 53 private long-term care insurance policies. A copy of the article and Consumers Union's "Long-Term Care Maze" are attached to my testimony. What we found was disappointing. All 53 of the policies we looked at had at least one major flaw. All of the policies were expensive.

Some of the key findings of the article were:

People with existing health problems are often denied coverage. Some companies reject as many as 30 percent of applicants; others have waivers for pre-existing conditions.

The policies are expensive, with premiums for a 65-year-old as much as $100 a month, and for a 75-year-old as much as $260 a month. Companies are free to raise the premiums charged to policyholders.

Some policies cover only skilled and intermediate care, and not custodial care, the potentially longest lasting kind of care. Many others restrict the benefits of custodial care.

While 61 percent of patients enter a nursing home without being hospitalized, 72 percent of the policies examined by Consumer Reports required prior hospitalization before any benefit could be provided.

Few policies had protection against inflation, which can seriously erode the value of the policy over time. Only one company had builtin inflation protection, and less than half offered an optional inflation rider.

More than half of the policies evaluated had vague language that could be used to deny coverage for people with Alzheimer's disease.

Another disconcerting fact about private long-term care insurance is the amount of money that is diverted from the pool of funds available for benefits to pay for the costs of marketing, administration and profits.

Forty to fifty percent of premium dollars are expected to go towards these costs. If the Medicare supplement insurance market is any guide, some companies will need even more money for marketing, administration and profits. We are disturbed by these facts, and they have encouraged us to seek public policy options that would enable us to get more bang for the long-term care buck.

The other option is a social insurance program that provides efficient protection for all people, with progressive financing. Consumers Union supports a social insurance solution to the long-term care problem. But we recognize that budget constraints may force Congress to enact a long-term care program that does not cover all of the long-term care costs.

In the interest of providing constructive suggestions, I will outline three options for enabling Congress to significantly improve consumers' "bang for the long-term care buck" without over-burdening the Federal budget.

I will not take the time to describe the details now, but briefly, they are, first, voluntary Medicare part C. Under this option, the Medicare-eligible could buy voluntary long-term care insurance available directly from the government.

Second, competitive selection of private companies. Private companies would compete for the right to sell long-term care insurance policies. And third, policy standardization. The government would establish uniform definitions for key policy terms and would set standard policy coverage that could not be varied.

We did not include the NAIC model act in the analysis of options because we do not believe it will be very effective at improving this market. Some of its provisions are a small step in the right direction, but the improvements it will make are marginal. We believe that public policy makers should have their sights set higher and should aim for more substantial improvements in the market.

Some of the problems that are not adequately addressed by the NAIC model include: One, the low expected value of the policies; the expected, not actual, loss ratio required would be 60 percent, with a good deal of latitude in the methodology for projecting the expected loss ratio; two, consumer confusion resulting from the proliferation of policies with slight variations from one to another; three, failure to address inflation; four, lack of protection for poor health risks; five, unaffordability; six, prior hospitalization requirement; and, six, absence of compensation for consumers who drop policies after considerable cash buildup should have accumulated.

Chairman Stark's proposed requirement that benefits not be conditioned on prior hospitalization is an improvement to the NAIC model. We are concerned, however, that Chairman Stark's certification proposal could do more harm than good.

"Twisting", convincing a client to switch policies, thereby increasing exclusions for preexisting conditions, and "loading up", selling multiple overlapping policies, are two types of abuses prevalent in the Medigap market.

A U.S. Government "seal of approval" would actually help agents convince the elderly to change policies, and hence be subject to new waiting periods, preexisting condition restrictions, and higher premiums. Certification could also lead agents to convince consumers to buy more policies than would be desirable.

What would the long-term care market look like in 30 years if Congress endorses the NAIC model act, with modifications as proposed by Chairman Stark? Here are our predictions:

Twenty-five percent of the elderly would have policies, if one assumes that 100 percent of the elderly would pay up to 5 percent of their income for a policy that pays $50 per day in benefits.

Under this optimistic assumption, private insurance would pay 7 percent of nursing home expenditures. If only 50 percent of the elderly buy policies, less than 4 percent of nursing home costs would be paid by private policies.

Private insurance would reduce Medicaid expenditures on long-term care by only 1 percent, if 25 percent of the elderly have policies.

Millions of moderate-income people will decide to forego private long-term care insurance because of their concerns that the restrictions in the policy will keep it from helping them when they need long-term care, or because they are confused by the array of variations between the policies.

The value of most policies would be seriously eroded by moderate inflation. While some policies offer 10 years of limited inflation protection through an optional inflation rider, most have no inflation protection.

Inflation over an additional 20-year period would dramatically decrease the value of the daily benefits, even for policies that have a limited inflation rider.

Many consumers would be rejected for coverage because of preexisting conditions.

Millions of low to moderate-income consumers would be unable to afford private long-term care insurance and would be without protection.

Many consumers would be under considerable budget pressure due to the high premiums paid for long-term care insurance.

Millions of families will be forced into poverty because of the cost of unreimbursed long-term care.

This picture is not satisfactory. We urge you to consider policy options that will truly benefit consumers.

I would like to take a minute to walk you through our maze. I don't know if my voice will carry, but let me tell you this portrays a man turning 65, and deciding to buy a long-term care policy, and under the first scenario, if you follow the route downward, his application is rejected because of a preexisting condition, chronic bronchitis.

If you follow the chart to the left, you find that this particular person decides to transfer his assets to his children, and then qualifies for medicaid. Under another route—I don't know, could I shout?

If this person does qualify for a policy, 15 years elapse. As you know, the price of these policies is quite high, and under this scenario he decides to drop the policy, ends up entering the nursing home and then depleting his assets. He might qualify for Medicaid under that path, after selling his house or divorcing his wife to pay the high cost.

Under this scenario, he keeps the policy in force when he enters the nursing home. If he is unlucky, his claim is rejected for a variety of reasons, some of which are addressed by Chairman Stark's proposal.

Assuming his claim is not rejected, the bottom of the maze shows what percentage of his bill will be paid under modest inflation. As you can see, it is somewhat low if the policy does not have any protection against inflation, it might pay only 21 percent of the cost of the stay.

That concludes my testimony. Thank you, Mr. Chairman.

[The statement of Ms. Shearer follows:]

Testimony of

GAIL SHEARER

MANAGER, POLICY ANALYSIS

CONSUMERS UNION

Mr. Chairman and members of the Subcommittee, Consumers Union* appreciates the opportunity to present our views on private long-term care insurance. We commend the Subcommittee for holding this hearing and Chairman Stark for his leadership on this important issue.

My testimony today will focus on the performance of the private long-term care insurance market today and under Chairman Stark's proposed program of federal standards. The key points are as follows: First, the private long-term care insurance market is not presently meeting consumers' needs and will not do so in the future without substantial government intervention. Second, there are several very good policy options for improving market performance to enable it to meet consumers' needs. The NAIC model regulation, even with Chairman Stark's improvements, does not go far enough.

POOR PERFORMANCE OF THE PRIVATE LONG-TERM CARE INSURANCE MARKET

A crucial question that Congress must address is: what price are we willing to pay in order to allow the private insurance market to insure the good risks? Are we willing to divert 10 percent, 30 percent or 50 percent of scarce long-term care dollars for this privilege? Consumers Union believes that if Congress chooses to allow the private insurance system to be a major player in the solution to the long-term care problem, then Congress must take unusually strong steps to assure that the private market provides high value products. Neither the unguided free market nor the current National Association of Insurance Commissioners (NAIC) regulations will be sufficient to significantly improve the performance of this market.

In May 1988, Consumer Reports published an in-depth evaluation of 53 private long-term care insurance policies. (A copy of the article and Consumers Union's "Long-Term Care Maze" are attached to my testimony.) What we found was disappointing. All 53 of the policies we looked at had at least one major flaw. All of the policies were expensive. Some of the key findings of the article were:

-- People with existing health problems are often denied coverage. Some companies reject as many as 30 percent of applicants; others have waivers for pre-existing conditions.

-- The policies are expensive, with premiums for a 65-year-old as much as $100 a month, and for a 75-year-old as much as $260 a month. Companies are free to raise the premiums charged to policyholders.

-- Some policies cover only skilled and intermediate care, and not custodial care -- the potentially longest lasting kind of care. Many others restrict the benefits for custodial care.

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*Consumers Union is a nonprofit membership organization chartered in 1936 under the laws of the State of New York to provide information, education and counsel about consumer goods and services and the management of family income. Consumers Union's income is derived solely from the sale of Consumer Reports, its other publications and films. Expenses of occasional public service efforts may be met, in part, by nonrestrictive, noncommercial contributions, grants and fees. In addition to reports on Consumers Union's own product testing, Consumer Reports, with approximately 3.5 million paid circulation, regularly carries articles on health, product safety, marketplace economics and legislative, judicial and regulatory actions which affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support.

-- While 61 percent of patients enter a nursing home without being hospitalized, 72 percent of the policies examined by Consumer Reports required prior hospitalization before any benefit could be provided.

-- Few policies had protection against inflation, which can seriously erode the value of the policy over time. Only one company had built-in inflation protection, and less than half offered an optional inflation rider.

-- More than half of the policies evaluated had vague language that could be used to deny coverage for people with Alzheimer's disease.

Another disconcerting fact about private long-term care insurance is the amount of money that is diverted (from the pool of funds available for benefits) to pay for the costs of marketing, administration and profits. 40 to 50 percent of premium dollars are expected to go towards these costs. If the medicare supplement insurance market is any guide, some companies will need even more money for marketing, administration and profits. We are disturbed by these facts, and they have encouraged us to seek public policy options that would enable us to get more bang for the long-term care buck.

Another disturbing conclusion one must draw from the Consumer Reports article is that the variation in policy options is overwhelming to the average consumer, and denies the consumer the opportunity to compare the merits of alternative policies in a rational and effective way. Attached to my testimony is a table that shows many of the ways that the long-term policies Consumer Reports examined vary. For example, daily policy benefits range between $40 and $100, or might be a percent of actual charge, or might vary by level of care. Inflation protection varies. Type of facility included varies (e.g., skilled nursing, intermediate, custodial, home). Requirements for prior hospitalization (or prior care at a skilled facility) vary.

The degree of variation does not serve consumers well. Consumers are precluded from comparing the prices of similar policies -- too many things vary from one policy to another. Unfortunately, by redesigning the policy to eliminate some of the restrictions, the premium will need to increase, further aggravating the affordability problem.

OPTIONS FOR IMPROVING PRIVATE MARKET PERFORMANCE

In addressing the long-term care problem, Congress faces a clear choice. One option is a primarily private patchwork system of low-value, high-cost private insurance, accessible to healthy people with high incomes, combined with means-tested medicaid protection for the poor and the middle class who spend-down their assets. The other option is a social insurance program that provides efficient protection for all people, with progressive financing. Consumers Union supports a social insurance solution to the long-term care problem. But we recognize that budget constraints may force Congress to enact a long-term care program that does not cover all of the long-term care costs. In the interest of providing constructive suggestions, I will outline three options for enabling Congress to significantly improve consumers' "bang for the long-term care buck" without over-burdening the federal budget.

Voluntary Medicare Part C

Under this option, the Medicare-eligible could buy (voluntarily) long-term care protection through the Medicare program, in a way similar to Part B. However, unlike Part B protection, 100 percent of the costs of the program would be paid through the premium. There is no question that the premium would be high, but should compare favorably with private insurance premiums since the Medicare program has a solid history of very low administrative costs of three percent. In contrast to the relatively low-efficiency of the private market, Medicare returns 97 percent of revenues collected in the form of benefits.

Premiums could be scaled to income, or partly "flat" and partly income-related (as in the catastrophic bill and the Long Term Care Assistance Act). If income-related, there should be a cap on the maximum premium in order to encourage participation by higher income people.

Karen Davis, Ph.D., and Diane Rowland, M.P.A., (professor and research associate, respectively, at the Johns Hopkins University School of Hygiene and Public Health) proposed an optional Medicare Part C to cover nursing home care, home health services and day hospital services. [Karen Davis and Diane Rowland, Medicare Policy: New Directions for Health and Long-Term Care, The Johns Hopkins University Press, Baltimore, 1986] Under their proposal, coinsurance would be set at 10 percent, and out-of-pocket expenses limited to $3000 per year. People would be eligible to enroll for the coverage at age 60, but benefits would not be initiated until a person had enrolled for at least five years. Premiums would be 4 percent of income for those enrolling at age 60, and would increase for those postponing enrollment.

Competitive Selection of Private Company(ies) to Sell Government-Designed Policies

The second option could also have relatively low administrative costs but could allow for a larger private sector role in implementing the program. Under this approach, the government (presumably the Department of Health and Human Services, following the direction of the Congress) could design a standard long-term care policy, with three or four option levels (e.g., low, medium, high, each covering different dollar amounts of coverage) and would allow private insurance companies to bid for the right to market the policy on behalf of the government. Competition could be set up regionally, thus allowing several companies to participate. The companies that would "win" the right to market the policy would be those that could assure that they would not divert substantial funds away from the money available to pay benefits.

This proposal is similar to an option explored recently in Massachusetts to develop a state long-term care insurance plan that could be administered by private insurers. [See Beyond Chaos and Catastrophic Costs: A Long Term Care Plan for Massachusetts Elderly, Report of The Special Commission on Elderly Health Care, April 1987, pages 39 - 45]

Standardization of Private Insurance Market

The third public policy option could provide an even greater role for private insurance companies and is likely to significantly increase the value consumers receive for their long-term care dollars. This option involves standardization. Under standardization, the government would establish uniform definitions for key policy terms (e.g., terms such as skilled nursing facility and custodial care facility) and restrict the variations allowed for other insurance policy provisions (such as length of waiting period or inclusion of home care). Policy standardization should be distinguished from "minimum standard" types of regulation. With minimum standards, insurers are free to offer benefits greater than the minimum standard. With standardization, no such variation is allowed.

The goal of standardization would be to limit the policy features that vary from one policy to another to simplify the market and facilitate price competition. While restricting consumer choice on most policy features, the regulation should seek to offer significant differences in the one or two policy features that do vary. For example, standardization of the long-term care market might include:

-- standard definitions of terms such as skilled nursing facility, intermediate nursing facility, custodial nursing facility;
-- uniform waiting period (_e.g._, 20 days);
-- benefit levels that are uniform for different types of facility offered by any one policy;
-- proportional benefit (_e.g._, 50 percent of nursing home benefit) for home care;
-- no prior hospitalization requirement;
-- coverage of Alzheimer's disease;
-- automatic inflation adjustment;
-- guaranteed renewable;
-- waiver of premium.

Once all of the above features were standardized, regulators could develop three or four varying levels of the benefit level. For example, the daily benefit level options could be:

Option	Benefit level
LTC1	$50 per day
LTC2	$75 per day
LTC3	$100 per day

Consumers could consider what benefit level they desire and then compare prices of _similar_ competing policies. Not only would consumers benefit directly and be less confused, but this simplification of the market should greatly reduce marketing costs and lead to higher value products.

The private sector "solution" does have some serious drawbacks. First, unlike the Medicare Part C approach, premiums would be flat (_i.e._, unrelated to income). This is the most regressive type of financing, and would keep private policies out of reach of people with low and moderate incomes. The second drawback is that insurance companies could screen out relatively high risks, protecting themselves against adverse selection. Both of these problems have solutions: explicit subsidization of premiums and mandatory open seasons, respectively. But at some point, Congress must consider whether a larger direct government role is preferable to such a heavily regulated private role.

Inflation presents a third problem area for the private sector. The private market is not able to handle inflation well since premium revenue (unlike the payroll tax) does not automatically grow with inflation.

The State of Massachusetts adopted a standardization approach for the medicare supplement insurance market. The regulation established three levels of medigap coverage. All medigap policies sold in Massachusetts are required to comply with one of the three benefit options and can not be modified. The regulation has been extremely effective. In 1984, Consumer Reports rated the most popular medigap policy sold in Massachusetts as the top medigap policy in the country. [Consumer Reports, June 1984, p. 347] In 1986, the General Accounting Office reported that the Massachusetts Blue Cross/Blue Shield Medex individual policies had a 1984 loss ratio of 98 percent, thus assuring consumers an extremely high value insurance product.

NAIC Model Regulation

We did not include the NAIC model act in the analysis of options because we do not believe it will be very effective at improving this market. Some of its provisions are a small step in the right direction, but the improvements it will make are marginal. We believe that public policy makers should have their sights set higher and should aim for more substantial improvements in the market.

Some of the problems that are not adequately addressed by the NAIC model include: (1) the low expected value of the policies (the expected, not actual, loss ratio required would be 60 percent, with a good deal of latitude in the methodology for projecting the expected loss ratio); (2) consumer confusion resulting from the proliferation of policies with slight variations from one to another; (3) inflation; (4) lack of protection for poor health risks; (5) unaffordability; (6) prior hospitalization requirement; and (6) absence of compensation for consumers who drop policies after considerable cash buildup should have accumulated.

Chairman Stark's proposed requirement that benefits not be conditioned on prior hospitalization is an improvement to the NAIC model. We are concerned, however, that Chairman Stark's certification proposal could do more harm than good. "Twisting" (convincing a client to switch policies, thereby increasing exclusions for pre-existing conditions), and "loading up" (selling multiple overlapping policies) are two types of abuses prevalent in the medigap market. A U.S. government "seal of approval" would actually help agents convince the elderly to change policies, and hence be subject to new waiting periods, pre-existing condition restrictions, and higher premiums. Certification could also lead agents to convince consumers to buy more policies than would be desirable.

What would the long-term care market look like in thirty years if Congress endorses the NAIC model act, with modifications as proposed by Chairman Stark? Here are our predictions:

-- 25 percent of the elderly would have policies, if one assumes that 100 percent of the elderly would pay up to 5 percent of their income for a policy that pays $50 per day in benefits. Under this optimistic assumption, private insurance would pay 7 percent of nursing home expenditures. [Brookings Institution] (If only 50 percent of the elderly buy policies, less than 4 percent of nursing home costs will be paid by private policies.)

-- Private insurance would reduce Medicaid expenditures on long-term care by only 1 percent, if 25 percent of the elderly have policies. [Brookings].

- Millions of moderate income people will decide to forego private long-term care insurance because of their concerns that the restrictions in the policy will keep it from helping them when they need long-term care, or because they are confused by the array of variations between the policies.
- The value of most policies would be seriously eroded by moderate inflation. While some policies offer 10 years of limited inflation protection through an optional inflation rider, most have no inflation protection. Inflation over an additional 20 year period would dramatically decrease the value of the daily benefits, even for policies that have a limited inflation rider.
- Many consumers would be rejected for coverage because of pre-existing conditions.
- Millions of low to moderate income consumers would be unable to afford private long-term care insurance and would be without protection.
- Many consumers would be under considerable budget pressure due to the high premium paid for long-term care insurance.
- Millions of families will be forced into poverty because of the cost of unreimbursed long-term care.

This picture is not satisfactory. We urge you to consider policy options that will truly benefit consumers.

Thank you very much for the opportunity to present our views on this important legislation.

ATTACHMENT

TABLE
VARIATION IN PRIVATE LONG-TERM CARE INSURANCE POLICIES EVALUATED IN CONSUMER REPORTS

Provision	Range or Description of Variations
Daily benefit for care in a covered facility	-- $40 to $100/day; -- Some policies pay 80% of actual charges up to $80/day; -- 1 policy pays 100% of actual cost; -- 1 policy pays 100% of eligible charges up to $75/day; -- 1 policy pays $75 for skilled care, $50 for intermediate care, and $25 for custodial care.
Waiting period (the number of days a policyholder must be in a facility before coverage begins)	-- 0 days to 100 days.
Maximum benefit for each period (*i.e.*, one stay in a nursing home)	-- 730 days to unlimited days or -- $60,000 to unlimited dollars.
Maximum benefit for all periods (i.e., all nursing home stays)	-- 730 days to unlimited days or -- $60,000 to unlimited dollars.
Coverage of skilled nursing facility care	-- Covered by all policies, but: -- One policy pays half benefits for first 50 days, with no waiting period; -- One policy pays for custodial care only in a skilled facility.
Coverage of intermediate nursing facility care	-- Most but not all policies cover; intermediate care, but: -- For some policies, coverage depends on company's interpretation; -- Some policies have shorter benefit period for this care; -- Some policies have reduced daily benefit for this care; -- One policy covers only custodial care provided in an intermediate care facility.
Coverage of care in a custodial care facility	-- Several but not all companies offer some coverage; -- Three companies had shorter benefit period for custodial care; -- Five companies paid benefits only after pre-confinement in skilled or intermediate care facility, with reduced benefits that are paid over a shorter period.

TABLE - page 2

Coverage of home care	-- More than half of the policies cover home care, sometimes as part of basic package but often as a separate rider; -- Definitions of what "home care" covers varied: most covered convalescent care, homemaker or companion services; some covered skilled nursing care; a few included care in hospices and adult day-care centers; -- The benefit is typically one half the daily benefit paid for skilled or intermediate care; -- Some policies require previous nursing home or hospital confinement and would cover home care only if its starts within 14 days after leaving the nursing home or hospital; -- Other policies do not require prior hospitalization or nursing home care, and apply the regular waiting period.
Prior hospitalization	-- 72% of the policies require a hospital stay of at least 3 days before entering a nursing home; the others do not.
Alzheimer's Disease	-- Some policies clearly state that Alzheimer's disease is covered (though in most cases coverage is subject to the prior hospitalization requirement); -- Vague policy language leaves ambiguity about Alzheimer's coverage of many policies.
Inflation adjustment	-- One company has built-in inflation protection; -- A few companies pay benefits based on actual charges; -- Some companies offer an inflation rider that protects against inflation; -- Most policies offer no protection against inflation.
Renewability	-- Many policies are "guaranteed renewable" (i.e., the company must renew coverage each time the policyholder pays the premium); -- Some policies are "conditionally renewable," allowing the insurer to cancel the policy if it cancels all similar policies in the state.
Waiver of premium	-- Some (but not all) policies allow policyholders to stop paying premiums once they have been in a nursing home for a certain period.

Who can afford a nursing home?

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Who can afford a

This year, 2.3 million of the nation's elderly will be living in a nursing home. Three decades from now that number will nearly double. A year in a nursing home now costs on average $22,000 or more. By the year 2018, it will cost about $55,000 if inflation stays at recent moderate rates.

Who will pay the bill?

Medicaid, the Federal program that finances health services for the poor, paid half of the $38-billion that went into nursing-home care in 1986. Most people aren't poor when they enter a nursing home, but they become poor soon after.

The other half of the $38-billion came out of the pockets of nursing-home residents or of their children, who often find themselves squeezed between the financial needs of their own family and the burden of caring for aged parents.

Contrary to popular belief, Medicare, the Federal program that provides health care for the aged, pays only a tiny fraction of the cost of nursing-home care.

The Reagan Administration believes that the Federal government has no role to play in providing long-term care unless you're poor. The nonpoor, it tells us, should look to private insurance companies for protection against the potentially devastating financial consequences of a prolonged stay in a nursing home. As a result, long-term-care insurance policies, unknown until a few years ago, have proliferated. Currently, some 70 companies, ranging from familiar giants like Aetna and John Hancock to lesser-known firms like Reserve Life and Pilgrim Life, have entered the field. For this report, we analyzed 53 of their policies.

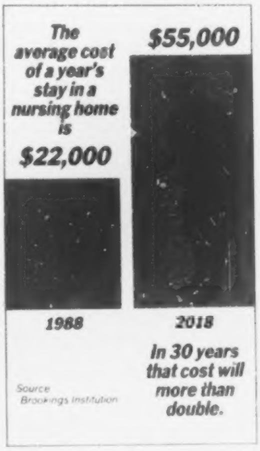
We'd like to report that private insurance policies can meet the increasingly urgent need for long-term-care coverage at a moderate cost. But many of the insurance policies we looked at were very expensive, severely limited in their coverage, or both. People who buy them at age 65 may have to pay as much as $100 a month for adequate coverage. People who try to shop for them will run into a crazy quilt of charges, waivers, and limitations that confuses even the insurance agents who sell the policies.

Illustrations by Pelco
Charts by Corinne Abbazia Hekker

Defining the policy

Simply stated, long-term-care insurance pays a set amount each day for a specified period of time that a policyholder stays in what's called a "covered nursing facility." Unlike other kinds of health insurance, these policies usually don't reimburse the policyholder for fees actually charged. The fixed benefit is one major drawback of nearly all such policies. Should you buy a policy today and enter a nursing home 10 years from now, you may find that the benefit pays a much smaller part of the actual cost than you thought it would at the time you bought the policy. Only a few policies offer a rider that adjusts the benefit annually for inflation.

Furthermore, you'll find huge differences in dollar benefits, in definitions of covered nursing facilities, in the length of time benefits are paid, in limitations on coverage, and in eligibility for benefits. Those differences are spelled out in the Ratings on page 304.



Source: Brookings Institution

Type of facility covered

There are three types of long-term-care facility: skilled, intermediate, and custodial. A policy may or may not cover care in all three types, and different policies may define the three types of facility differently. In general, the definitions are the following:

Skilled nursing. Such care must be prescribed by a doctor, given by a skilled nurse, and be available for 24 hours a day. These facilities are licensed by the state, and daily medical records are kept on each patient.

Intermediate. In such facilities, care may require the skills of a nurse, but the level of care is somewhat less than that given in a skilled-care facility. For example, a nurse may be on hand only to give patients injections or to change their bandages. The facility may be licensed and may provide post-hospital and rehabilitative nursing care.

Custodial. Care here means helping a person with such routine activities as getting out of bed, walking, eating, and bathing. It may be given by people without professional skills or training, but some insurance policies may require that the facility be licensed.

The best policies pay benefits for all three kinds of care in all three types of facility. Buy less than the best, and you may discover that your insurance doesn't cover the type of care you require.

Note that policies can imply coverage where none exists. For example, a policy might provide coverage for all three *types* of care, but require that the care be given in only *one* type of facility, such as a nursing home that provides skilled care.

Custodial care is sometimes covered only if it is provided in a skilled- or intermediate-nursing facility. Some policies pay no benefits for custodial care, no matter where it's given. That's a major deficiency. Very few people need skilled care for long periods; much of the care in nursing homes is of the intermediate or custodial variety. Stroke victims, in particular, often require a long period of custodial care while recovering.

Qualifying for benefits

Most policies require beneficiaries to be hospitalized for at least three days before

nursing home?

they enter a nursing home. And usually the nursing home must continue to provide care for the illness or condition that put the individual in the hospital.

Furthermore, the person must check into the nursing home within a certain period after checking out of the hospital. That period is usually 30 days, but it can be as short as 14 days or as long as 90 days. These rules can limit the usefulness of the insurance. Such debilitating conditions as arthritis and Alzheimer's disease usually do not require hospitalization. Only about 40 percent of all nursing-home patients check in after a hospital stay.

A few policies do not demand a hospital stay before paying benefits for long-term care. But the companies that issue them, including Blue Cross/Blue Shield and Metropolitan Life, do retain the power to decide who is eligible for benefits. Some companies, including MidAmerica and Continental Casualty, offer buyers a choice of policies with and without "prior-hospitalization" rules. Of course, the ones without these rules generally cost more.

We found nine policies free of either the prior-hospitalization rule or the company's veto of a policyholder's eligibility for nursing-home coverage.

Other restrictions may stand in the way of custodial care, which is potentially the longest-lasting and hence the most costly type of care. John Hancock's individual policy, for example, pays for care in a custodial facility only after 14 continuous days of skilled-nursing care. Aetna pays for a policyholder's first stay in a custodial facility only after a stay in either a skilled or an intermediate-care facility.

What's not covered?

No policy pays benefits for stays in rest homes or old-age homes. Nor do they pay for stays in mental hospitals or alcohol and drug rehabilitation centers. Most significantly, long-term-care policies tend to limit benefits for existing health problems and for Alzheimer's disease, the very reasons people might seek coverage in the first place.

Most companies limit coverage for "preexisting conditions"—those illnesses or diseases a buyer has when the policy is issued. The preexisting-conditions clause acts as a gatekeeper, turning away those who want to buy the coverage because they know they need it. If a company does not have a preexisting-conditions clause, it usually retains the power to decide who's eligible for benefits.

Most policies define a preexisting condition as any health problem experienced by the policyholder in the six months prior to buying the policy. But a number of policies count back one to three years.

If the insurance company sells a policy to a person with such a preexisting condition, it sets a waiting period before coverage for that condition can begin. These periods range from six months to two years. So if a heart condition lands someone in a nursing home three months after the policy was issued, the company won't start paying benefits immediately.

Virtually all the policies exclude care for mental and nervous disorders. Does that include Alzheimer's disease, a debilitating condition that's diagnosed in about half of all nursing-home patients?

Although Alzheimer's is not specifically excluded, about half the policies we looked at said something like "we won't pay for confinements due to mental illnesses except those with demonstrable organic disease." Alzheimer's disease is a degenerative brain disease with symptoms that mimic those of mental illness. It's considered an organic disease and therefore would seem to be covered. But is it a *demonstrable* organic disease? Only a biopsy or an autopsy can confirm a diagnosis of Alzheimer's disease.

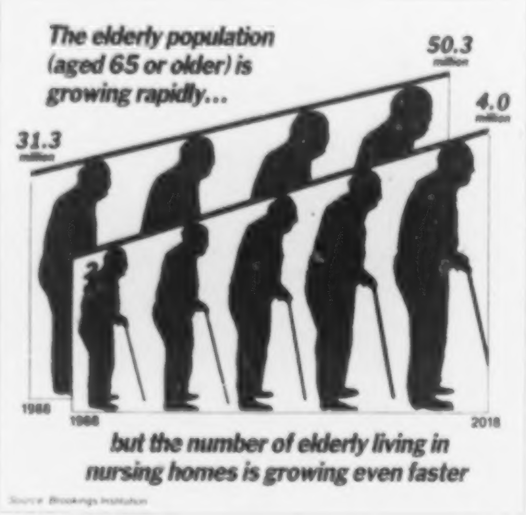
In our opinion, the vague policy language gives insurance companies too great an opportunity to contest a claim on the grounds that Alzheimer's disease has not been demonstrated. A company suddenly flooded with claims from policyholders with Alzheimer's disease might rely on that language as a basis for denying nursing-home coverage.

Other policies clearly state that Alzheimer's disease is covered. But here, again, there's a catch. Many of these policies also impose the prior-hospitalization rule. Most Alzheimer's patients, as we've noted, do not require hospitalization before they enter a nursing home.

When we asked an Aetna salesman about this, he replied: "To tell you the honest-to-goodness truth, if a doctor didn't find some way to get you into a hospital, then you're in trouble."

How large a benefit?

Daily benefits range from $25 to $100. Some policies offer a choice of benefit amounts. Obviously, it makes sense to pick a policy with benefits that closely match local nursing-home costs. A policy



Source: Brookings Institution

paying $40 a day when the local nursing home costs $140 isn't much help. A call to two or three homes will help to establish a reasonable range of daily charges. Nationally, the average cost of a nursing home is $60 a day.

Sometimes insurance companies pay smaller benefits for custodial care than for skilled and intermediate care. The Gerber Life policy, for instance, pays a $75 benefit for skilled-nursing care, a $50 benefit for intermediate care, but only $25 if a policyholder needs custodial care.

When do benefits begin?

Policyholders can often decide when they want their coverage to start—as soon as they enter a nursing home, 20 days later, or even 100 days later. The longer this "waiting period" (sometimes called an elimination period), the cheaper the policy.

How long do benefits last?

The best policies pay benefits for an unlimited number of days for each stay in a nursing home and an unlimited number of days for all nursing-home stays. Those stays in a nursing home are sometimes called "periods of confinement" or "benefit periods."

Other policies pay benefits for a specific number of days, ranging from 730 (two years) to 3650 (10 years) for one stay, and from 730 days (two years) to 2555 (7 years) for all nursing-home stays. A few policies don't limit the number of days they'll pay benefits. They set dollar maximums instead.

In order to receive benefits for a repeat stay in a nursing home, the policyholder must usually have been out of a nursing home for at least 180 days. And when he or she returns, the waiting period starts all over again, so coverage doesn't begin immediately. Waiting periods for preexisting conditions don't begin again, however.

Sometimes a policy will have a shorter benefit period for intermediate or custodial care than for skilled-nursing care. This could be a severe limitation, since nursing-home patients require skilled care less often than intermediate or custodial care. Nearly 40 percent of all nursing-home patients stay longer than six months. Chances are good that those longer-staying patients needed intermediate or custodial care, not skilled care.

Are policies renewable?

Many policies are "guaranteed renewable," a desirable feature that insurance companies like to highlight in their sales literature. The company must renew coverage each time the policyholder pays the premium.

Beware of policies that are only "conditionally renewable." The insurer can cancel the policy provided it also cancels all other similar policies in a state. That could happen if an insurance company discovers it is losing money on this relatively new type of coverage.

A number of policies are written for groups such as the American Association of Retired Persons (AARP), or even for a fictitious group set up by the insurance company for marketing and regulatory purposes. The group holds the master contract and issues certificates to individual policyholders. The master contract for the group can be canceled, but policyholders are often able to continue the same coverage on their own.

What else to look for?

Here are other features we looked for in a policy:

Home care. More than half the policies in our study paid benefits for care at home. These benefits are usually offered as part of the basic policy coverage, but sometimes they are offered as a separate policy or as a rider at an additional premium. Home care typically covers convalescent care, homemaker or companion services, and occasionally even skilled-nursing care. A few policies define home care broadly enough to include care in hospices and adult day-care centers.

Typically, the home-care benefit is one half the daily benefit paid for skilled nursing or intermediate care, but that's where the similarity among policies ends. There's wide variation in eligibility for home-care benefits and in when those benefits begin and end.

Policies that require previous nursing home or hospital confinement would usually pay for home care only if it starts within 14 days after leaving the nursing home or hospital. Policies that do not have such a requirement would generally start paying as soon as the regular waiting period has ended.

Continued on page 6

What's in a good policy?

Features	*Recommended*	*Your policy*
Daily nursing-home benefit	$80.00	$______
Waiting period	20 days	______
Maximum benefit period for one stay	4 years	______
Maximum benefit period for all stays	Unlimited	______
Does it pay full benefits in:		
Skilled-nursing facility?	Yes	______
Intermediate facility?	Yes	______
Custodial facility?	Yes	______
(If not, what does it pay?)		
If it has a prior-hospitalization rule, does coverage begin within 30 days after a hospital stay of at least 3 days?	Yes	______
Does it pay home-care benefits?	Yes	______
Does it pay these without requiring nursing-home care, or a hospital stay?	Yes	______
Does it have waiver of premium?	Yes	______
Is it guaranteed renewable for life?	Yes	______
Is Alzheimer's disease covered by specific policy language?	Yes	______
Does the premium stay level for life?	Yes	______
What is the Best's rating of the company?	A or A+	______
No premium is recommended; premiums vary with the age of the policyholder.	—	$______

Pitching the policies

It has never been easy to understand insurance policies. It's even tougher when the agents selling them don't understand what they're selling. And when the policy sold is brand-new, it takes a miracle to avoid misunderstanding, duplication of coverage, or even inadequate coverage.

A CONSUMER REPORTS reporter listened to sales pitches given by six insurance agents in New York and Virginia. Two agents represented Aetna; the others represented Union Bankers, Bankers Life and Casualty, Gerber Life, and Mutual of Omaha. Our reporter witnessed no miracles.

She found confusing presentations from agents who were either ignorant of the provisions in their policies or who deliberately misstated them. An Aetna agent in Virginia admitted, "I've never had to explain this to someone." Some agents were remarkably low key, acting as if they didn't want to sell the policy.

Alzheimer's confusion

About half of all nursing-home patients suffer from Alzheimer's and related diseases, so shoppers would want to know whether a policy provided coverage for such illnesses. They wouldn't have found out listening to these agents or reading their sales brochures. The agents' confusion may well reflect their company's indecision over whether to provide such coverage.

The Aetna agent in Virginia allowed that "it was questionable" whether his policy covered the disease, but said the company was "still looking at it." He added, "It's a mental disease, and they're not sure."

No wonder he was confused. The sales brochure sent by Aetna said Alzheimer's was covered, but the actual language in the policy was less specific. It said that the policy did not cover confinements for mental disease or disorders without demonstrable organic disease. As we point out on page 3, that language may or may not mean the disease is covered.

The Union Bankers agent said Alzheimer's was covered, but the brochure he left noted that the policy didn't cover nursing-home stays for "mental illness or nervous disorders." Did that mean Alzheimer's is covered? Our reporter could only guess.

What's covered?

Coverage is the guts of a long-term-care policy, but agents were of no help defining the coverage or discussing the policy limitations. Here's how the Aetna agent in New York handled these questions:

What about intermediate-care coverage? The agent fumbled for his sales brochure and replied: "They define it here somewhere." What about skilled nursing care? "On this plan, you don't have to worry about the definition," he assured us.

As for limitations on coverage, he said there were none. "Once you have this policy, you're covered for everything." Everything? The policy specifically says it does not provide benefits for six months if a nursing-home stay results from a preexisting condition.

A competitor also had trouble explaining coverage. The agent from Bankers Life and Casualty said that intermediate care was the same thing as "convalescent care" and that skilled care meant that "they do a little more medical than the others."

When asked whether any prior hospitalization is required before skilled-nursing benefits could be paid, the agent for Mutual of Omaha said: "I don't think so. I've never seen where you have to be hospitalized first." He didn't look very far. That's just what his company's sales brochure said.

What Medicare pays

Many people think that Medicare covers nursing-home stays (see box page 14). Actually, it pays for skilled nursing-home care in Medicare-approved facilities for only 20 days and then all but $67.50 per day for the next 80 days. After 100 days, Medicare pays nothing.

Here's what the agents said:

The Gerber Life salesman said that 70 percent of all applicants for Medicare benefits were turned down "because Medicare doesn't have funds for skilled care." But when Medicare does accept an individual, he said, "after 100 days, they wash their hands of you."

The Bankers Life and Casualty agent said that Medicare paid for 100 percent of home health-care costs. "It's a wonderful benefit," he said, declaring that Medicare pays "for girls to come in" and "help do your hair."

The agent had let his imagination run away with him. Medicare's home-care benefit is very limited, and it certainly doesn't pay for beautician services. It pays only for part-time, intermittent skilled care and for physical or speech therapy. The provider must participate in Medicare.

What about rate hikes?

It wasn't always easy to get a straight answer about whether premiums could go up or policies could be renewed.

The Bankers Life and Casualty agent incorrectly said the premiums would never increase, wrongly labeling this policy feature as "guaranteed renewable." The policy and the sales brochure say that the company can raise premiums if it raises them for all policies like the one the agent was selling.

The Aetna agent in Virginia also assured our reporter that the premiums would *not* increase. "Once these premiums are set, you'll be paying them forever." He even double-checked his sales manual. "No, they shouldn't go up," he repeated. The sales literature he gave to our reporter didn't say one way or the other, but Aetna's policy is similar to the one from Bankers Life and Casualty. Both companies can raise rates for everyone who owns the same policy in the state.

The Mutual of Omaha salesman was thoroughly confused. His policy is not guaranteed renewable, but he replied, "It is and it isn't. If the state does not permit the company to renew, then we have to pull the policy." While that statement is true enough, it has nothing to do with the renewability feature of his policy.

Mutual of Omaha's sales brochure revealed that the company could refuse to renew a policy, if it refuses to renew them for all those who own that particular policy in the same geographic area of the policyholder's state.

Which one is best?

Naturally, each agent declared his policy the best. The feature they all cited as evidence was the length of time benefits would be paid—unquestionably important, but not necessarily the only measure of superiority.

The Gerber salesman touted his policy as the best because he said it paid benefits for "eight continuous years." And he knocked the American Progressive policy. But as you can see from the Ratings, the Gerber policy was hardly the best, ranking near the bottom. The American Progressive policy ranked close to the top.

What's best is a combination of features. To help you figure out which policy is best, ask for answers to all the questions listed in the box on page 4.

If you get answers that are vague or that contradict the sales literature, ask for a specimen policy. The policy will tell you exactly what's covered and what's not, setting out all the limitations you need to know about.

An agent might be reluctant to give you a specimen policy, however. When our reporter asked the Mutual of Omaha salesman for one, he refused to supply it. If that happens, write to the company. If a company doesn't give you what you need, go to one that does.

Policies usually pay home-care benefits until the regular benefit period maximum has run out. But we found policies that paid home-care benefits for other periods: 30 days, 90 days, one year, two years, or even three years.

Inflation adjustments. The greatest danger facing policyholders is the lack of inflation protection. The $40, $75, or even $100 daily benefit paid by policies today may be woefully inadequate if you need nursing-home care 5 or 10 years from now.

Only one company, Great Republic, sells a policy with built-in inflation protection. The benefit automatically increases by 5 percent each year for as long as a policyholder hangs on to the policy.

Other companies allow policyholders to buy a rider that automatically raises benefits by some amount each year, usually 5 percent. These automatic increases usually stop after 10 years. The riders generally add between 15 and 40 percent to the premium, depending on the coverage.

A few policies pay benefits based on the actual nursing-home charges. If these charges go up, then the benefits will rise as well.

Waiver of premium. Many insurers relieve policyholders of paying further premiums once they've been in a nursing home for a period of time, usually 90 days. This feature is often part of the basic policy, but occasionally policyholders will have to pay extra for it.

Assistance in finding care. A few sellers employ care coordinators who help people find facilities that are covered by their policies. Other companies have toll-free telephone numbers that policyholders or their families can call to find out about nursing homes in their areas.

Will the price go up?

As with life insurance, the older you are when you buy the policy, the more expensive it is. A 75-year-old buying Great Republic's long-term-care policy will pay $3143 a year. A 55-year-old can buy the same policy for $611 a year.

In most cases, the premiums remain "level"—they don't increase after someone buys the policy. (Premiums that do increase annually or every few years as the policyholder grows older make a policy far less desirable.)

But a level premium is not necessarily as level as it looks. A company can increase a so-called level premium on your policy provided it also increases the premium for everyone else in your state who bought the same policy.

One CONSUMER REPORTS reader wrote us about his experience with a policy from Massachusetts Indemnity and Life: The

Continued on page 10

Guide to the Ratings

Listed in order of estimated overall quality. Within red rules, plans were judged approximately equal in quality.

① **Premium.** Premium paid at age 65, expressed as a monthly amount for the purposes of the Ratings.

② **Daily benefit.** The amount of money a policy pays for each day spent in a covered care facility.

③ **Waiting period.** The number of days a policyholder must be in a facility before coverage actually begins.

④ **Each period.** The number of days a policy pays for one stay in a nursing home. Some policies have dollar maximums instead.

⑤ **All periods.** The number of days a policy pays for all nursing-home stays.

⑥ **Skilled.** Policy pays benefits for care in a skilled-nursing facility.

⑦ **Intermediate.** Policy pays benefits for care in an intermediate-nursing facility.

⑧ **Custodial.** Policy pays benefits for care in a custodial-nursing facility. Care is usually limited to helping people perform routine activities.

Ratings

Nursing-home insurance

Company name	① Premium	② Daily benefit	③ Waiting period
Great Republic with Skilled Care at Home Rider 206-285-1422	$ 67.50 [1]	$ 80	20
John Hancock Mutual Life Protectcare - Individual 617-421-6000	76.52 [1]	100	20
American Progressive Life & Health 800-243-8214	57.24	80	20
Bankers Life and Casualty with Home Health Care Benefit Rider 312-777-7000	53.54	50	20
Bankers Multiple Line with Home Health Care Benefit Rider 312-777-7000	53.54	50	20
Certified Life with Home Health Care Benefit Rider 312-777-7000	53.54	50	20
Union Bankers with Home Health Care Benefit Rider 312-777-7000	53.54	50	20
Equitable Life and Casualty 800-453-3245	52.56	60	30
Life Insurance Co. of Connecticut 800-645-9676	68.04	80	20
Metropolitan Life Group Policy for Williamsburg Landing 212-578-2211	95.00 [2]	40 [4]	60
Farwest American Assurance Co. 503-224-7740	50.67	60	20
Bankers Life and Casualty without Home Health Care Benefit Rider 312-777-7000	38.30	50	20
Bankers Multiple Line without Home Health Care Benefit Rider 312-777-7000	36.30	50	20

[1] *Represents one-twelfth of company's annual premium. Monthly premium, if available, would probably be higher.*

[2] *Composite rate means the company charges the same premium at all ages.*

[3] *Represents weekly premium.*

[4] *Benefit paid for one person; policy pays $80 for first spouse of a couple living together.*

[5] *Pays 80 percent of actual charge with maximum policy payment of $80 a day.*

[6] *Pays 100 percent of actual cost.*

[7] *Pays for "usual and customary" charges up to a maximum of $50.*

[8] *Pays 100 percent of "eligible" charges up to a maximum of $75.*

[9] *Pays this for skilled care, pays $50 for intermediate care and $25 for custodial care.*

[10] *Pays 75 percent of charges based on negotiated rates with participating provider.*

[11] *Daily equivalent of company's $2000 a month benefit.*

[12] *Pays half benefits for first 90 days, but waiting period does not apply.*

[13] *Pays for custodial care only.*

[14] *Depends on company's interpretation.*

[15] *Shorter benefit period.*

[16] *Reduced daily benefit.*

[17] *Only after 14 days skilled-nursing care.*

⑨ **Home care.** Policy pays benefits for care at home.

⑩ **No prior hospitalization.** Most policies require a hospital stay of at least three days before entering a nursing home. Policyholder must also enter nursing home within 30 days of hospital discharge. A — indicates the policy has a prior-hospitalization rule. Variations of this rule are listed under advantages and disadvantages.

⑪ **Alzheimer's coverage.** The policy language specifies that Alzheimer's disease is covered.

⑫ **Inflation adjustment.** An optional rider or other arrangement which increases benefits by a set percentage each year for a certain number of years.

⑬ **Preexisting conditions.** Policy covers care for preexisting conditions—ailments or illnesses a policyholder has at the time a policy is issued.

⑭ **Level premiums.** A premium that doesn't increase with the age of a policyholder is highly desirable.

⑮ **Guaranteed renewable.** Company will always renew coverage each time the premium is paid. Without this protection, a company can usually cancel the policy if it cancels all other policies of that type in a state.

⑯ **Waiver of premium.** Feature allows policyholders to stop paying premiums once they've been in a nursing home for a certain period, usually 90 days.

⑰ **Rejection rate.** The percentage of applicants rejected by a company. A — indicates company provided no information.

⑱ **Substandard risks.** Someone who has health problems can buy insurance with a higher premium, **P**, or a waiver, **W**, that excludes coverage for those problems. Waivers are undesirable.

Maximum benefit		*Type of facility*														
④ Each period	⑤ All periods	⑥ Skilled	⑦ Intermediate	⑧ Custodial	⑨ Home care	⑩ No prior hospitalization	⑪ Alzheimer's coverage	⑫ Inflation adjustment	⑬ Preexisting conditions	⑭ Level premiums	⑮ Guaranteed renewable	⑯ Waiver of premium	⑰ Rejection rate	⑱ Substandard risks	Advantages	Disadvantages
unlimited	unlimited	▣	✓	✓	✓	—	—	✓	—	✓	✓	✓	10%	—	B,E	l
2190	2190	✓	▣	▣	✓	✓	✓	✓	—	✓	✓	✓	20-25	—	A,C	—
1095	1825	✓	✓	▣	✓	—	—	—	—	✓	✓	✓	5	—	—	—
1095	unlimited	✓	✓	✓	✓	—	✓	✓	—	✓	✓	✓	10	—	—	—
1095	unlimited	✓	✓	✓	✓	—	✓	✓	—	✓	✓	✓	10	—	—	—
1095	unlimited	✓	✓	✓	✓	—	✓	✓	—	✓	✓	✓	10	—	—	—
1095	unlimited	✓	✓	✓	✓	—	✓	✓	—	✓	✓	✓	3	—	—	—
3650	$250,000	✓	✓	▣	✓	—	—	—	—	✓	✓	✓	7	—	—	l
1095	1825	✓	✓	▣	✓	—	—	—	—	✓	✓	✓	5	—	—	l
unlimited	unlimited	✓	✓	✓	✓	✓	✓	✓	—	✓	—	—	10	P	D,F	b,e,h
1460	2190	✓	✓	▣	✓	✓	✓	✓	—	✓	✓	✓	12	—	A	—
1095	unlimited	✓	✓	✓	—	—	✓	✓	—	✓	✓	✓	10	—	—	—
1095	unlimited	✓	✓	✓	—	—	✓	✓	—	✓	✓	✓	10	—	—	—

▣ *Benefits paid only after pre-confinement in skilled or intermediate facility; benefits are reduced and paid over a shorter period.*

Key to Advantages

- A - No prior hospitalization required, company does not arbitrarily decide whether policyholder requires nursing-home care.
- B - Built-in inflation adjustment.
- C - Toll-free number available to policyholders needing help with nursing-home selection.
- D - Care coordinator available to help policyholders find nursing homes.
- E - Intermediate or custodial care must follow either hospital confinement of two days or skilled confinement of 10 days.
- F - Benefit represents 100 percent of incremental cost for retirement-home resident.
- G - Product operates according to HMO service-provided principles.
- H - Will verify that institution complies with group certificate language as a covered facility.
- I - Must check into nursing home within 90 days of discharge from hospital.
- J - Company has large variety of home-care coverages available in separate policy or rider.

Key to Disadvantages

- a - Policyholder must check into nursing home within 14 days of discharge from a hospital—a very short time for decisions.
- b - Company arbitrarily decides whether policyholder requires nursing-home care.
- c - Has premiums that go up annually as policyholder gets older.
- d - Has premiums that go up every few years.
- e - Conditionally renewable, or group insurance contract.
- f - Must remain in retirement community group to keep coverage.
- g - Pays for custodial care that takes place in a skilled or intermediate facility.
- h - Intermediate facilities and custodial facilities (Personal Care Homes) must be on site and owned by retirement community.
- i - Pays only if the facility qualifies, irrespective of level of care.
- j - Pays for intermediate or custodial care that takes place only in a skilled facility.
- k - Pays for skilled, intermediate, or custodial nursing care only in a skilled facility.
- l - Company has Best's rating of B or lower, or is not assigned by Best's.

Ratings of Nursing-home Insurance

Continued

Company name	① Premium	② Daily benefit	③ Waiting period	Maximum benefit ④ Each period	 ⑤ All periods	⑥ Skilled	⑦ Intermediate
Certified Life without Home Health Care Benefit Rider 312-777-7000	$ 36.30	$50	20	1095	unlimited	✓	✓
Union Bankers without Home Health Care Benefit Rider 312-777-7000	36.30	50	20	1095	unlimited	✓	✓
John Hancock Mutual Life Flex Plan 88 - Group Policy 617-421-6000	16.11 [3]	[5]	90	1460	1460	✓	[4]
Group Health Cooperative of Puget Sound Security Care Agreement of Metropolitan Life 212-578-2211	80.00	[6]	30	1460	1460	✓	✓
World Life & Health of Pennsylvania 800-523-1260	53.75 [1]	50	0	730	unlimited	✓	✓
Transport Life 817-390-8060	89.56	80	0	1460	$204,400	✓	✓
AMEX Life 415-492-7000	33.00 [1]	56	20	1460	1460	✓	✓
Aetna Life and Annuity Long Term Care Plan 203-273-0123	33.02	50	20	1460	1460	✓	✓
Reserve Life 214-670-8700	37.32	80	100	1095	1095	✓	✓
Acceleration Life 614-764-7000	83.16	80	100	1825	1825	✓	✓
MidAmerica Mutual Life with Prior Hospitalization 612-331-6370	67.20	60	20	$90,000	$90,000	✓	✓
Continental Casualty with Home Health Care Rider 312-822-5000	43.25	60	15	1825	2555	✓	✓
Harvest Life 616-888-7200	44.22	50	20	1095	1825	✓	✓
Mutual Protective 402-391-6500	43.95 [1]	60	20	1095	1460	✓	✓
Continental Casualty without Home Health Care Rider 312-822-5000	38.40	60	15	1825	2555	✓	✓
MidAmerica Mutual Life without Prior Hospitalization 612-331-6370	78.60	60	20	$100,000	$100,000	✓	✓
Prudential, American Association of Retired Persons (available April, 1988) 800-523-5800	55.00	50	90	1095	1095	✓	✓
Federal Home Life 800-253-0836	42.50 [1]	50 [7]	20	1095	1825	✓	✓
Blue Cross of Washington and Alaska 800-231-0519	69.56 [1]	75 [8]	20	2190	2190	✓	✓
AIG Life Group Long Term Care Certificate with Extended Home Care Rider 302-594-2000	68.20	60	20	1825	1825	✓	—
American Travellers Life without Supplemental Home Health Care Policy 215-343-1000	24.30	50	0	730	730	✓	[13]
NN Investors Life with Home Health Care Rider 800-338-0257	37.80	60	20	1000	1500	✓	✓
Columbia Life 717-784-2716	42.50	50	20	1460	1460	✓	[13]
Travelers Long Term Care Plan Trust 203-277-0111	66.75	50	90	$75,000	$75,000	✓	✓
American Republic with Home Health Care Benefit 515-245-2000	66.42	60	60	$90,000	$90,000	✓	✓
NN Investors Life without Home Health Care Rider 800-338-0257	29.16	60	20	1000	1500	✓	✓
Penn Treaty Life with Supplemental Coverage for Home Health Care 800-222-3469	75.19	50	0	730	730	✓	✓
Prudential, American Association of Retired Persons (Previous Plan) 800-523-5800	48.75	50	90	1095	1095	✓	✓
American Republic without Home Health Care Benefit 515-245-2000	56.44	60	60	$90,000	$90,000	✓	✓
Colonial Penn Life 800-523-4000	55.15 [1]	60	20	1095	unlimited	✓	✓
Gerber Life 914-761-4404	39.50	75 [9]	100	1825	$187,500	✓	[13] [14]
Finger Lakes Long Term Care, Subsidiary of Blue Cross and Blue Shield of Rochester 716-454-1700	102.56	[10]	100	1825	1825	[11]	[11]
American Sun Life with Home Convalescent Policy 305-647-3111	56.81	60	0	1095	unlimited	✓	—
United General Life with Home Convalescent Care Coverage 813-544-8881	39.83 [1]	60	0	730	unlimited	✓	—
Pilgrim Life Three Diamond Plan with Home Private Duty Nursing Benefit of $100 per day 215-534-8800	65.19	67 [12]	0	730	730	✓	✓
Penn Treaty Life without Supplemental Insurance Coverage for Home Health Care 800-222-3469	52.24	50	0	730	730	✓	✓
American Sun Life without Home Convalescent Policy 305-647-3111	31.32	60	0	1095	unlimited	✓	—
Pilgrim Life Three Diamond Plan without at Home Private Duty Nursing 215-534-8800	52.20	67 [12]	0	730	730	✓	✓
Life and Health of America 215-567-1248	100.00	40	20	730	730	✓	✓
United General Life without Home Convalescent Care Coverage 813-544-8881	28.08 [1]	60	0	730	unlimited	✓	—

Type of facility												
⑧ Custodial	⑨ Home care	⑩ No prior hospitalization	⑪ Alzheimer's coverage	⑫ Inflation adjustment	⑬ Preexisting conditions	⑭ Level premiums	⑮ Guaranteed renewable	⑯ Waiver of premium	⑰ Rejection Rate	⑱ Substandard	Advantages	Disadvantages
✓	—	—	✓	✓	—	✓	✓	✓	10%	—	—	—
✓	—	—	✓	✓	—	✓	✓	✓	3	—	—	—
✓	✓	✓	✓	✓	—	✓	✓	✓	5-10	—	D	b
✓	✓	✓	✓	✓	✓	✓	—	—	20-30	—	D,G	b,e
✓	✓	—	—	—	—	✓	✓	✓	3	P,W	C	l
✓	✓	—	—	—	—	✓	—	✓	3-5	—	H	e
[illegible]	✓	—	✓	✓	—	✓	✓	✓	10-20	—	C,I	—
[10]	✓	—	—	✓		✓	✓	✓	10	—	C	—
[illegible]	✓	—	—	—	—	✓	✓	✓	5	—	—	—
✓	✓	—	—	—	—	✓	—	✓	3	W	—	e
✓	✓	—	✓	—	—	—	✓	✓	—	—	—	c
—	✓	—	—	✓	—	✓	✓	✓	15	P	—	g
✓	✓	—	—	—	—	✓	—	✓	1	—	—	e
—	✓	✓	✓	—	—	✓	✓	✓	17	P	A,C	g
—	—	—	—	✓	—	✓	✓	✓	15	P	—	g
✓	✓	✓	✓	—	—	—	✓	✓	—	—	A	c
✓	✓	✓	✓	—	—	✓	✓	✓	—	—	A,C	—
✓	✓	—	—	—	—	✓	—	✓	1	—	—	e
✓	✓	✓	—	—	✓	✓	✓	✓	20-22	—	D	b
—	✓	—	✓	—	—	✓	✓	✓	20	—	D	i
[illegible]	—	—	—	—	—	✓	✓	—	2-4	P	J	a,l
—	✓	—	—	—	—	✓	✓	✓	13	P	C	g
[illegible]	—	✓	—	—	✓	✓	✓	✓	2	P,W	A	l
[14]	✓	✓	✓	—	—	✓	✓	✓	—	—	A,C	g
—	✓	✓	✓	—	—	✓	✓	✓	15	—	A,C	g
—	—	—	—	—	—	✓	✓	✓	13	P	C	g
✓	✓	—	—	—	—	✓	✓	✓	10	P,W	—	a,l
✓	✓	✓	—	—	—	✓	—	✓	8	—	C	e
—	—	✓	✓	—	—	✓	✓	✓	15	—	A,C	g
—	✓	—	—	—	—	✓	✓	✓	2	—	—	g
[illegible] [illegible]	—	—	—	—	—	✓	✓	—	—	—	—	a
[13]	✓	✓	✓	✓	—	✓	✓	✓	30	—	D	b
—	✓	—	—	—	—	—	—	✓	—	—	—	d,e,k,l
—	✓	—	—	—	—	—	—	✓	10 or less	—	—	j,c,l
✓	✓	—	—	—	—	✓	—	—	1	P	—	e,l
✓	—	—	—	—	—	✓	✓	✓	10	P,W	—	a,l
—	—	—	—	—	—	—	—	✓	—	—	—	d,e,k,l
✓	—	—	—	—	—	✓	—	—	1	P	—	e,l
✓	—	—	—	—	—	✓	✓	—	2	—	—	a
—	—	—	—	—	—	—	—	✓	10 or less	—	—	j,c,l

Key to Advantages

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Insurance regulators look the other way

Every state has a department of insurance that's supposed to protect consumers by regulating the insurance policies sold in that state and by supervising the activities of insurance companies. But with few exceptions, regulators are reluctant to look too closely at long-term-care insurance policies, for fear that insurance companies will refuse to provide any coverage at all rather than tailor coverage to meet stern regulatory requirements.

"We are treating long-term care differently than other lines of insurance," says Fred Bodner, chief of the New York Insurance Department's Health and Life Policy Bureau. "We're not going to approve a policy if it's a rip-off, but we're not going to turn it down if it isn't wonderful."

The National Association of Insurance Commissioners (NAIC), which writes model laws for all states to adopt, has written one for long-term-care policies. So far, 11 states have adopted this model, and companies selling policies in these states must comply with its provisions.

States in which insurance policies must meet the NAIC standards are: Arizona, Hawaii, Indiana, Iowa, Kansas, Nebraska, North Carolina, North Dakota, Oklahoma, Oregon, and Virginia. Wyoming and Georgia were about to adopt the model law as we went to press.

The model has some good rules. Waivers denying coverage for specified health conditions are prohibited, and companies cannot offer substantially greater benefits for skilled nursing care than for custodial and intermediate care. Policies must also be guaranteed renewable, but state insurance commissioners may allow cancellation in limited circumstances.

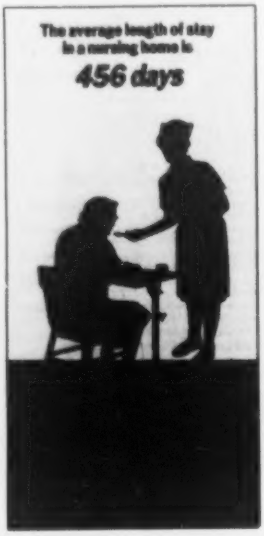
The NAIC model permits other features we consider undesirable: Companies can require a hospital stay before providing benefits for nursing-home care, and can require that a policyholder receive skilled care before qualifying for intermediate, custodial, or home-care benefits. Although the NAIC model prohibits companies from excluding coverage for Alzheimer's disease, it doesn't require policies to specifically spell out that the disease is covered.

Not addressed by the NAIC model law is the need for standard language for long-term-care policies, much like the standard language found in a homeowners policy. Without it, consumers will be forced to rely on confused agents and equally confusing sales brochures.

When CU asked all 50 state-insurance commissioners what complaints had developed from the sale of long-term-care insurance, we learned that consumers complained most often about the unanticipated limitations on the coverage provided by their policies. Consumers believed that their policies covered them for a particular kind of care when, in fact, no such coverage existed.

Members of the NAIC advisory committee that wrote the model law considered requiring companies selling long-term-care policies to include the telephone number of the state-insurance department on forms given to policyholders who are thinking about replacing their policies. That way consumers could call their state regulators if they couldn't decipher a policy. But the committee scrapped the idea when insurance companies argued it would not provide a substantial benefit to consumers.

If insurance regulators don't help buyers of long-term-care policies, who will?


The average length of stay
in a nursing home is
456 days

premium for his long-term-care policy had jumped a whopping 150 percent, from $180 to $450, in a single year.

Long-term-care policies don't have much of a history. As a result, insurance-company actuaries may be unable to predict nursing-home use or future costs accurately. Some insurance companies may be pricing their policies too low to cover the promised benefits in the future.

Are you insurable?

Someone who's sick and ready to check into a nursing home can't buy a policy from most companies. Many insurance companies have instructed their agents to weed out "undesirables" before applications reach the home office. If an agent sees that a person can't get out of bed alone or learns that a person has osteoporosis or Alzheimer's disease, the agent won't even deliver a sales pitch. An Aetna agent in Virginia told our reporter that she had to come to his office to hear the sales presentation, probably to see whether she could actually walk.

People who are turned down for life or health insurance might nevertheless be good risks for long-term-care insurance. "Someone with terminal cancer may be a better risk than someone with mild arthritis," says Karl Michaelson, director of health-products underwriting for Aetna. "We do not like to insure people who need aids in getting around—like walkers, canes, and oxygen."

Some companies are choosier than others. Rejection rates vary from 1 percent for Harvest Life, Pilgrim Life, and Federal Home Life to 30 percent for Finger Lakes Blue Cross/Blue Shield.

Many companies offer coverage to people with less-than-perfect health by applying "waivers," which exclude coverage for certain conditions. But buying a policy with a waiver for an illness that's likely to land you in a nursing home is a waste of money.

Instead of waivers, some companies offer coverage at higher rates to people who have health problems. Depending on the severity of the illness or condition, a "substandard risk" could pay as much as 100 percent more than a person whose health qualified him or her for the company's standard rate.

Evaluating the policies

We requested data from 81 insurance companies that sell long-term-care policies or that will start to offer them in the near future. Some told us they were withdrawing their policies and wouldn't have new ones ready in time for us to evaluate. Several companies, including Mutual of Omaha, United American, Combined American Life Insurance Co., American Integrity, National States Life, and Central

States Health and Life, declined to provide the information we requested. (We obtained policies and rate information on some of those companies from state insurance departments, but decided not to include these policies in the Ratings, because the data are incomplete.)

We've listed several policies twice, once with their home-care provisions and once without them. We've included two policies sold by MidAmerica Mutual Life, as well as both the old and new policies underwritten by Prudential for the American Association of Retired Persons.

The Ratings show the plans based on the daily benefit amounts and waiting periods that companies said were selected most often by their customers. If a company didn't tell us which of its plans was most popular, we chose one.

Some of the policies are group policies that have the same characteristics as individual policies. Policies sold by AARP are an example.

To rank the policies, we paid special attention to six main features that contribute to a policy's overall quality: nursing-facility coverage, home-care benefits, restrictions, renewability, relationship of benefits to premium and other aspects of pricing, and underwriting (the process of selecting applicants for coverage). We assigned the most points for quality of coverage and absence of restrictions. We also give bonus points to policies with liberal home-care provisions.

We also examined each company's financial stability, as judged by the A.M. Best Co., which rates insurance companies from A+ (superior) to C (fair). If a company's Best's rating is B or poorer (or if the company is not assigned a rating), we've considered it a disadvantage, since a low rating suggests some risk the company may not be around to pay future benefits.

Should you buy?

We don't recommend long-term-care policies for anyone under age 60 unless the policy offers a good way to keep benefits current with inflation in nursing-home costs. For those over age 60, a policy from one of the top-rated companies might be a reasonable choice. People whose income and assets are fairly modest should not buy long-term care policies. They would quickly qualify for Medicaid benefits should they need to stay in a nursing home.

The best policies cover care in all three types of nursing facility and offer generous daily benefits and benefit periods. They also have a good price in relation to those benefits.

Even the best policies had minor deficiencies in their coverage, however. For example, the Great Republic policy has a generous $80 benefit, paid for an unlimited period. But the policy restricts the benefit to a lower amount for the first 50 days of skilled care. It compensates for that restriction somewhat by not requiring a waiting period before paying benefits. And it is the only policy with a built-in inflation adjustment, a highly desirable feature.

The John Hancock policy offers a generous $100 benefit for six years, a period that should cover most nursing home stays, and its coverage has only a few minor limitations. Buying the policy could be a problem, however. The company estimates its rejection rate at 20 to 25 percent. A company spokesperson says that this rejection rate could drop as John Hancock agents acquire more experience selling the policy.

The most popular policies sold by Bankers Life and Casualty and its subsidiaries, Bankers Multiple Line, Certified Life, and Union Bankers, offer coverage for care in all three types of facility, and the policy specifically says Alzheimer's disease is covered. But these policies ranked somewhat below the top companies because of their relatively low daily benefit ($50), which is available for only three years for each nursing home stay.

A high premium doesn't always buy higher-quality benefits. For example, compare the American Progressive Life policy with the Life and Health of America policy, which ranked next to last.

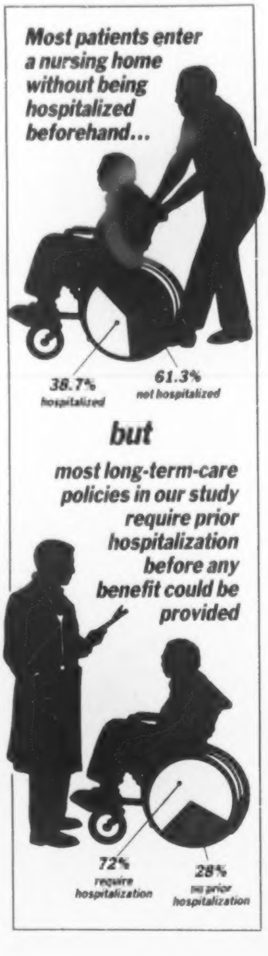
The former provides an $80 daily benefit for a monthly premium of $57.24. The policy offers benefits for three years for one nursing-home stay and five years for all stays. The Life and Health policy offers a skimpy $40 daily benefit (for only two years) yet commands a $100 premium.

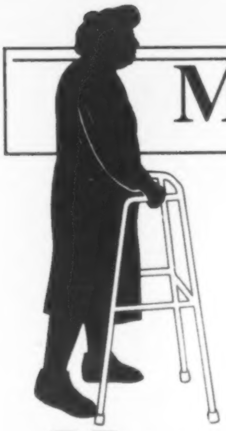
Buying a policy through a group doesn't necessarily mean you'll get more for your money. Neither the policy recently sold through the American Association of Retired Persons nor the policy that will replace it this spring ranked highly. They impose a 90-day waiting period before nursing-home benefits begin and pay benefits for only three years. (Visits by home-health-care workers count toward satisfying the 90-day waiting period.) Neither policy, however, requires a stay in a hospital before benefits start.

The old AARP policy has no provision to continue coverage if the group contract is cancelled; the new one does. An AARP spokesperson says that people who have bought the old policy have assurances from AARP that coverage won't end.

Insurance companies have come up with some innovative ideas. For example, Metropolitan's Security Care Agreement for Group Health Cooperative of Puget Sound provides service in accordance with the principles of a health maintenance organization. Patients receive service instead of dollar benefits. Since the benefits offered by this plan will cover 100 percent of the actual cost of nursing-home care, they should hold up well against inflation.

This plan did have its drawbacks. It paid benefits for a relatively short time (4 years), lacked a waiver of premium, and had a high estimated rejection rate (20 to 30 percent).





Must you die poor?

Mary Ann Mattingly, of Indianapolis, looked forward to a comfortable old age when her husband James retired from his job as a security guard at the Eli Lilly Co. The Mattinglys lived reasonably well on the $744 a month he received from his company pension plan and from Social Security. They even managed to dine out on occasion.

But James's health slowly began to deteriorate. He became confused. He could no longer walk. He needed someone to help him eat. In 1979, at the age of 72, he checked into the Eastside Health Care Center, an Indianapolis nursing home. By the time James died in 1986, the Mattingly family, despite a lifetime of work and the security of a pension, had sunk into poverty. It was either that or do without the care James needed in his final years.

James's first year in the nursing home cost $12,000—about $3000 a year more than the family's total annual income. Mary Ann applied for help from Medicaid, the Federal and state program that helps the poor pay their health-care bills. She learned she was too rich for Indiana's Medicaid program. The Mattinglys had accumulated $5000 of Eli Lilly stock, $3000 in a passbook savings account, $2000 in life-insurance cash value, $5000 in a certificate of deposit, and $300 in a Christmas-club savings plan.

The only way Mary Ann could keep James in a nursing home was to become impoverished. Medicaid pays the bills only after the family assets and income run out. That usually doesn't take long. On average, 13 weeks elapse from the time a patient is admitted to a nursing home until the spouse left at home is impoverished. It took Mary Ann Mattingly only nine months to spend on nursing-home care most of what the family had accumulated. When she was poor enough, Medicaid stepped in.

Each state has its own Medicaid rules. Indiana allowed Mary Ann to keep $2250 of her family's assets plus her household furnishings. (If she'd owned a home, she could have kept that, too.) But nursing-home care still took $477 a month of the Mattinglys' $744 monthly income, leaving $238 to cover rent, gasoline and insurance for the car, and food, and $29 for James's incidental expenses.

Once she became poor, Mary Ann, who had never taken a hand-out in her life, qualified for food stamps—as much as $75 worth a month, but more often $30 worth.

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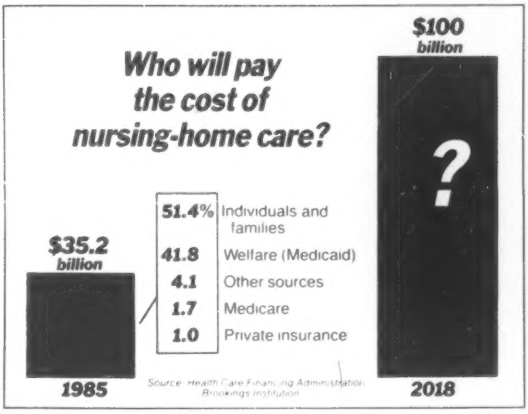

Source: Health Care Financing Administration, Brookings Institution

Special Federal funds to help poor people pay for utilities sometimes paid for her heating bills.

The Medicaid rules did give Mary Ann one way to protect her assets and avoid poverty: divorce. After 32 years of marriage, she wouldn't consider it.

"It was horrible," says Mary Ann. "There's still anger in me. Nobody can understand until they've experienced it. A lot of people today don't know what they have in store." Indeed they may not.

In the year 2030, people over 65 will make up 21 percent of the population, up from 12 percent in 1985. The fastest-growing age group is the "old-old," people 85 and older. Their need for long-term care is greatest.

Nursing-home costs have gone up almost as fast as the age of the population. The average annual cost of a year's stay in a nursing home is now about $22,000, but the cost rises to as much as $45,000 in metropolitan areas such as New York City. Medicaid pays for nearly half of those stays. Federal expenditures for nursing-home care grew tenfold from 1965 to 1980 and will quadruple by 1990.

For years, health economists and social-service planners have seen the shadow of these costs looming. But long-term care for the elderly has only recently won a place on the national agenda—as a seemingly intractable problem for the debt-ridden Federal government, as a giant financial headache for state governments that share the cost of the Medicaid program, as a painful crisis for more and more families, and lately as a marketing opportunity for insurance companies.

What to do?

In 1986, the Secretary of Health and Human Services, Dr. Otis Bowen, issued a report pointing out that Medicare, the health-insurance program for the elderly,

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did not protect people from the high costs of a catastrophic illness. The report focused attention on the financial consequence of stroke, heart attack, and other medical catastrophes. The reaction to the report spurred Congress to pass bills expanding Medicare to include coverage for catastrophic illnesses of *limited* duration.

But none of the bills do anything to help families pay for long-term care—the greatest source of economic catastrophe. Eighty percent of health-related costs that exceed $2000 a year are due to nursing-home and other long-term-care expenses.

Who then will pay?

The Reagan Administration's answer, echoed by the health-insurance industry: Consumers should buy long-term-care insurance policies, of the type rated in the accompanying report. That set off a small boom in this new insurance product. Unfortunately, few of the insurance policies we looked at adequately meet the need. And the cost of these policies—as much as $1230 a year for a 65-year-old—may well be beyond the means of those who need protection most.

Even those who can afford such policies for themselves or for their parents may find insurers unwilling to sell, usually because the person to be insured is already a candidate for a nursing home. Insurance companies aren't eager to insure people who are almost certain to generate a claim. A few companies in our survey estimated that they turned down as many as 20 or even 30 percent of potential buyers.

Insurance companies would prefer to market their policies to employers, who in turn would offer them to their employees, thus encouraging younger people to buy the insurance when they are still insurable and when the rates are low.

But private insurance for long-term care is a tough sell to employers and employees alike. Employers, some of whom already face huge liabilities for current and former employees' conventional health insurance, are unlikely to pick up the tab for yet another kind of insurance now or in the near future. At most companies that do offer long-term-care insurance, employees must pay the entire premium. But healthy workers either do not know what's ahead for them (estimates are that as many as one of every two people who reach age 65 will eventually land in a nursing home) or prefer not to think about it just yet. When Aetna Life Insurance Co. offered long-term-care coverage to its own employees, only 7 percent bought it. Ten percent of its retirees signed up.

A recent study by the Brookings Institution, using generous assumptions about people's ability to pay for long-term-care policies, predicted that by the year 2018 private insurance would cover only 7 to 12 percent of all nursing-home expenses. Brookings researchers believe that, at best, only one-quarter to one-half of the elderly would buy long-term-care policies.

Thus, for many low- and middle-income families, Medicaid and its prerequisite—spousal impoverishment—will remain the only feasible way to pay for long-term care, unless we find a better way.

Expanding the safety net

Soon the Federal government—and American taxpayers—will have to face the increasingly urgent need for a new social-insurance program that helps chronically ill and disabled people with the costs of long-term care before those costs impoverish them.

The need for universal long-term-care protection can be met through a new mandatory insurance program that complements Medicare and replaces the long-term-care portion of Medicaid. Or the current Medicare program could be expanded to include voluntary insurance paid for by premiums charged to participants.

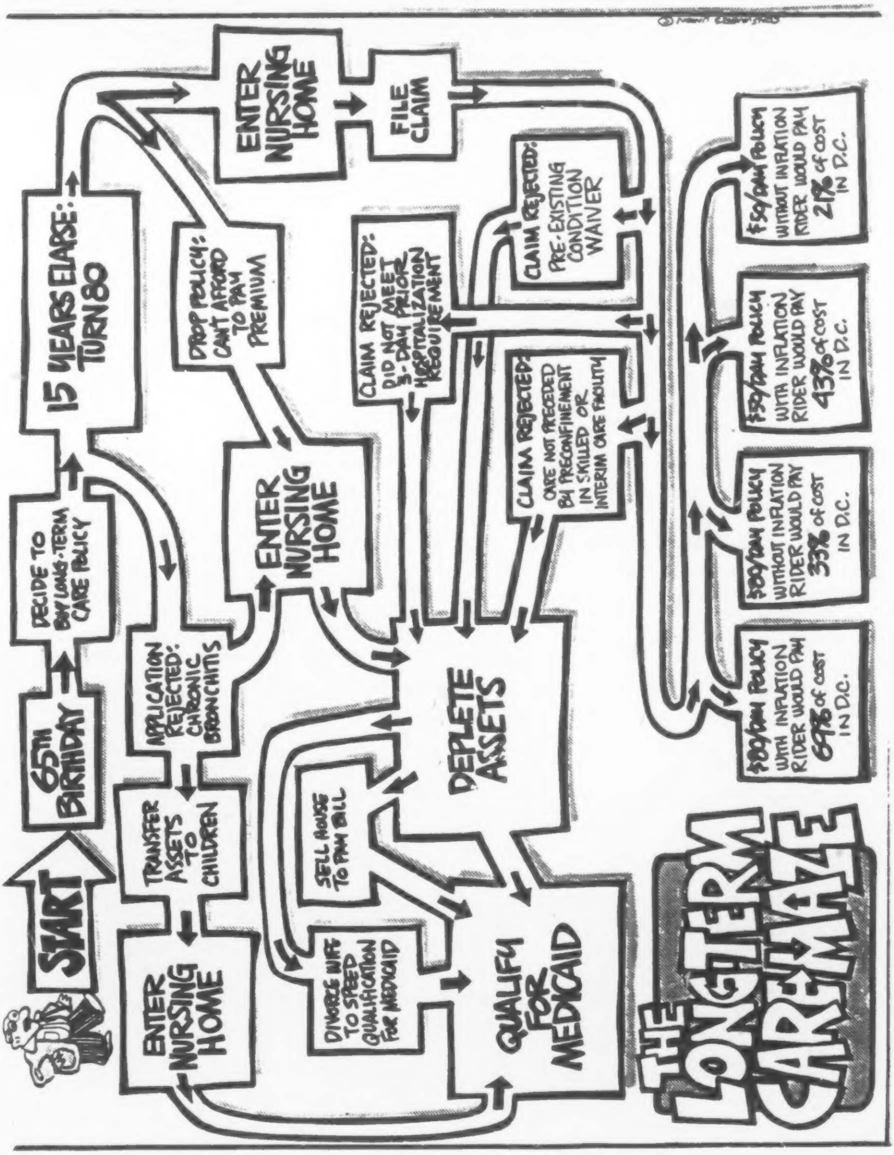
The private insurance system can't spread its costs over a large enough number of people to minimize the financial burden on any one person. Only the Federal government can do that. Funding long-term-care insurance through general revenues spreads the cost among everyone who's a future candidate for long-term care. And making the insurance available to (and required of) everyone eliminates the eligibility standards that now effectively withhold private insurance from those who need it most. A Federally mandated insurance program would also eliminate Medicaid nursing-home coverage, and with it the costs and stigma associated with Medicaid.

So far, however, the only long-term care proposal to surface in Congress addresses long-term care only at home, not in a nursing home. A bill introduced by Claude Pepper, the Democratic Congressman from Florida, would provide a range of home-care, physical-therapy, and homemaker services to the chronically ill elderly and to disabled people of all ages. It would be financed by applying that portion of Social Security taxes that pays for Medicare (1.45 percentage points) to all earned income rather than to the first $45,000 of income, as at present. Some 5 percent of American workers earn more than $45,000 a year; they pay a proportionally smaller tax for Social Security and Medicare than do the great majority of workers who earn $45,000 or less.

Although the Pepper bill, if it passes, may help keep some ill or disabled people out of institutions, it is only a first step toward correcting a health-insurance system that forces too many people into poverty. The bigger step—universal coverage for long-term care no matter where the service is rendered—remains to be taken. ■

What's available now

Program	*Nursing home*	*Home care*
Medicare	Skilled-nursing care covered only in approved facilities: 100% of eligible expenses for 20 days; all but $67.50 a day for next 80 days; nothing after that; no custodial or intermediate care.	Only part-time, intermittent skilled care and speech or physical therapy covered. Person must be confined to home and care-provider must agree to reimbursement under Medicare rules.
Medicaid	Skilled, intermediate, and custodial care covered once a person's assets and income drop below state Medicaid limits.	Part-time nursing and home-health aids provided if requested by physician for those eligible for Medicaid. States have the option to offer a variety of non-medical home-care services.
Medicare supplement policies	Benefits range from nothing to the policy limits for sharing the cost of care for days 21-100; after that, policies pay a set amount each day. Custodial or intermediate care usually not covered.	Usually nothing covered.
Ordinary health insurance policies	Very limited post-hospital, convalescent, skilled-nursing care covered, but usually no custodial or intermediate care.	Very limited post-hospital convalescent care may be covered
Veterans Administration	Skilled-nursing care provided only in VA facilities on a space-available basis for eligible veterans.	Chronically ill eligible veterans, eligible for medical, nursing, and rehabilitative care.


THE LONG-TERM CARE MAZE
START
65TH BIRTHDAY
DECIDE TO BUY LONG-TERM CARE POLICY
15 YEARS ELAPSE: TURN 80
ENTER NURSING HOME
FILE CLAIM
TRANSFER ASSETS TO CHILDREN
APPLICATION REJECTED: CHRONIC BRONCHITIS
ENTER NURSING HOME
DROP POLICY: CAN'T AFFORD TO PAY PREMIUM
ENTER NURSING HOME
CLAIM REJECTED: DID NOT MEET 3-DAY PRIOR HOSPITALIZATION REQUIREMENT
CLAIM REJECTED: PRE-EXISTING CONDITION WAIVER
CLAIM REJECTED: CARE NOT PRECEDED BY PRECONFINEMENT IN SKILLED OR INTERIM CARE FACILITY
DEPLETE ASSETS
SELL HOUSE TO PAY BILL
DIVORCE WIFE TO SPEED QUALIFICATION FOR MEDICAID
QUALIFY FOR MEDICAID
$80/DAY POLICY WITH INFLATION RIDER WOULD PAY 69% OF COST IN D.C.
$80/DAY POLICY WITHOUT INFLATION RIDER WOULD PAY 33% OF COST IN D.C.
$59/DAY POLICY WITH INFLATION RIDER WOULD PAY 43% OF COST IN D.C.
$59/DAY POLICY WITHOUT INFLATION RIDER WOULD PAY 21% OF COST IN D.C.

Chairman **Stark**. For the members' edification, attached to the copy of the Consumers Union testimony is a copy of that chart, as well as a copy of an article from the May 1988 issue of Consumer Reports dealing with a rating of nursing home insurance policies. I would recommend that, not only to the members and their staff, but to our interested members of the audience. It is an excellent summary of the limitations and varieties of programs that are available in the market. The Consumers Union is to be commended for bringing together a study of a complex market and presenting it in a clear manner.

Thank you very much.

Our next witness will be Mr. Douglas Peters, senior vice president of the Blue Cross-Blue Shield Association.

STATEMENT OF DOUGLAS S. PETERS, SENIOR VICE PRESIDENT, BLUE CROSS AND BLUE SHIELD ASSOCIATION

Mr. **Peters**. I am pleased to have the opportunity to testify today. Highlights of our plan products and their status are included in our submitted testimony.

The association and its member plans strongly support the concept of a public and private sector partnership as the best and only viable approach to a national long-term care policy. We believe there is a need for flexible, innovative options and improved public programs.

The private sector cannot address the needs of all segments of the population; however, we are confident that with certain Government incentives, we can increase significantly the number of people protected against the cost of long-term care.

We recommend that Congress clarify that long-term care insurance products be taxed on the same basis as noncancellable accident and health insurance. In this regard, our recommendations are quite consistent with those of the Brookings Institute, and we believe that insurers should meet certain requirements in order to qualify for this tax treatment. These requirements are referred to in our testimony.

Perhaps the most difficult issue Congress may address is the appropriate role for the Federal Government in the direct financing of long-term care benefits. At the heart of this debate is the question of whether a new entitlement program should be created to provide long-term care, or whether the Government should assume the responsibility for individuals based on their financial need.

The Blue Cross and Blue Shield Association would offer some recommendations for the Congress to consider in this debate. First, we believe that there should be the greatest possible dependence on private coverage for those who can afford the premiums, in order to make Federal dollars available for those whose needs the private sector cannot meet. This principle could be through an entitlement program or some other method.

Second, we believe that long-term predictability of Government benefits is necessary in order for consumers to plan for their retirement and to feel comfortable purchasing a private insurance policy. Long-term predictability is essential also for private insurers to design policies that provide comprehensive protection and coordinate effectively with any Federal program.

Third, we believe that the concept embodied in the recently enacted medicare catastrophic legislation—budget neutrality—is a sound one.

In conclusion, we endorse the basic concept of a public-private partnership as the most promising approach to assuring the availability of long-term-care financing and services, and we look forward to continuing discussions and working with the committee in these important matters.

Thank you very much.

Chairman **Stark**. Thank you, Mr. Peters.

[The statement of Mr. Peters follows:]

STATEMENT OF DOUGLAS S. PETERS, SENIOR VICE PRESIDENT, BLUE CROSS AND BLUE SHIELD ASSOCIATION

Mr. Chairman and Members of the Committee, I am Douglas Peters, Senior Vice President of the Blue Cross and Blue Shield Association. The Association is the coordinating organization for the 77 Blue Cross and Blue Shield Plans throughout the nation. Collectively, the Plans provide health benefits protection for more than 80 million Americans.

I am pleased to have the opportunity to testify on the appropriate roles for both the private sector and the government in addressing the needs of those who require long term care services. We strongly support the concept of a public and private sector partnership as the best and only viable approach to a national long term care policy. I also appreciate the opportunity to comment on the legislation, H.R. 5085, that would provide for a federal program of certification for long term care policies. We, also, are concerned that consumers be assured that they will receive value for their dollars spent for long term care products. Before commenting on these major issues, I would like to review briefly the current long term care financing problem and describe some of the products offered by Blue Cross and Blue Shield Plans.

Very briefly, the following statistics demonstrate the current long term care financing problem:

- Approximately 30 million Americans are over age 65. They comprise over 13 percent of our population, but will grow to over 18 percent, or 55 million, by the year 2030.
- The number of individuals over age 85 -- an age group particularly at risk for needing long term care services -- will grow three to four times as quickly as the general population.
- Individuals and their families pay over half of total nursing home expenses out of their pockets -- over $19 billion in 1986. Medicaid pays for most of the rest, but only after a family has exhausted nearly all financial resources.

Blue Cross and Blue Shield Plans Long Term Care Activities

Blue Cross and Blue Shield Plans and the Association have made development of long term care insurance policies one of our highest priorities. Thirteen of our Plans are now marketing these products, and soon two more will be offering policies.

Along with care provided in nursing homes, benefit programs cover a wide variety of home and community-based health services, including home health visits, adult day care, homemaker services, medical transportation, and respite care. Respite care is one type of non-traditional benefit needed by families of those suffering from chronic conditions. It covers services of trained personnel who give relief to family caregivers.

These long term care policies generally may be purchased by persons between the ages of 40 and 84. Premiums vary with age at initial purchase and with the benefit options selected. Rates are set at a level that will, over an expected lifetime, accumulate the funds necessary to meet the increasing need for services in later years.

Due to the lack of data on utilization and costs of long term care, most of the industry's early long term care policies were quite restrictive. These policies predominantly offered nursing home coverage. Alternative levels of care, such as home care or custodial care, were seldom offered.

In contrast, long term care insurance policies developed by Blue Cross and Blue Shield Plans more recently tend to offer benefits that are tailored to meet a variety of long term care needs. For example, several Blue Cross and Blue Shield Plans offer more traditional "service" benefits which base payment on the cost of services received rather than a fixed indemnity amount of so many dollars per day. This type of payment structure assures individuals that their insurance coverage will keep pace with inflation. Some policies also protect against inflation by incorporating features such as annual percentage increases in fixed payment amounts for covered services or periodic opportunities to increase benefit levels.

Our policies provide extensive coverage for home care services. Many policies also include individual case management of benefits in order to help assess a person's needs and provide care in the most appropriate setting.

The Roles of the Public and Private Sector in Providing Long Term Care Services

In order to assure that long term care services are available on as broad a basis as possible, we believe that there is a need for flexible, innovative private sector options for those who are able to pay for them and improved public programs to protect those who cannot participate in private programs -- that is, individuals already 85 years old and over, individuals currently suffering from chronic illness, and the low-income.

The Role of the Private Sector. The private sector cannot address the needs of all segments of the population. However, we are confident that, given proper government incentives, and our growing experience, the private sector can significantly increase the number of people protected against the cost of long term care.

The Blue Cross and Blue Shield Association, with our member Plans, performed extensive market research and actuarial analyses and used this as the base for designing our long term care products for the private market. Using this research, we have developed a number of recommendations for government action that we believe would make private insurance more widely available.

1) Market Incentives. First, we recommend the establishment of incentives for the sale and purchase of long term care insurance. The most important of these incentives is to clarify that long term care insurance products are to be taxed on the same basis as non-cancellable accident and health insurance. This would permit insurers to set aside a portion of annual premiums collected, and accumulate interest on these funds on a non-taxable basis. Insurers would be allowed to do this until the funds are sufficient actuarially to pay for future liabilities for long term care benefits.

We recommend that insurers be allowed to establish such reserves on a tax-favored basis after the insurance has been in force for one year, instead of the current two-year requirement. Under current law, insurers can not establish tax-favored reserves for most types of health insurance until the insurance policy has been in force for two years.

Allowing tax free reserve build up after one year would help insurers keep premiums as low as possible. We also recommend that long term care insurance be given the same tax-favored status granted to group health benefits. Specifically, benefits paid out, and employer contributions for, long term care insurance would be excluded from an employee's income.

Also, we believe that employers should be permitted to deduct contributions to long term care insurance as a current expense, and to offer such a benefit as part of a cafeteria plan.

Finally, we suggest that individuals be permitted to deduct qualified long term care expenses and premiums using the limited medical expense deduction allowed under Section 213 of the Internal Revenue Code. This section permits individuals to deduct medical expenses in excess of 7.5 percent of their adjusted gross income.

We believe these measures addressed particularly to the group market would provide employers and insurers with new incentives to provide long term care insurance.

2) Continued Regulatory Flexibility. Our second recommendation is for continued regulatory flexibility at all levels of government to support the development of a variety of private sector long term care financing mechanisms. Chairman Stark has introduced H.R. 5085 which would establish a voluntary certification program intended to assure the quality of long term care products. Under the certification program insurers would have to meet standards similar to those developed by the National Association of Insurance Commissioners' model act and regulation. The bill goes one step further than the NAIC and establishes additional standards including a minimum 24-month product and a prohibition on the use of any prior hospitalization requirements.

We are pleased that the Chairman's proposal recognizes the extensive work by both state regulators, consumers and the insurance industry in developing a regulatory framework that allows development of the market. If we are to continue the kind of creative product development that will provide insurance options to meet their needs, we must -- as the NAIC has done -- strike a delicate balance between safeguarding consumer protection and assuring the industry regulatory flexibility. The Blue Cross and Blue Shield Association and its member Plans were actively involved in the development of the NAIC long term care model act and regulations. And, we support their final products.

We are concerned, however, that further steps such as the establishment of additional minimum standards or the embodiment of the NAIC's work in federal statutes would be premature. For example, the NAIC's model act and regulations are sure to continue to evolve as long term care products mature. If the federal government references the model act in effect at a specific time, the law may be outdated within a short time. On the other hand, the Congress is likely to be concerned about referencing the most current NAIC model as a delegation of law-making authority to another body.

These concerns for continued flexibility should not be misinterpreted as disregard for consumer protection. The Blue Cross and Blue Shield Association is, in fact, very concerned that consumers receive realistic protection against the costs of long term care in exchange for their premium dollars.

For this reason, in order to qualify for favorable tax treatment, we recommend that insurers would have to meet certain requirements. Insurers should be required to provide coverage for a variety of services for not less than 12 consecutive months. Insurers also would have to offer coverage on a "guaranteed renewable" basis, which would prohibit cancellation of a policy on the basis of a policy holder's age or deteriorating health. In addition, the Blue Cross and Blue Shield Association supports a requirement that only insurers who are subject to the jurisdiction and regulation of at least one state regulatory agency could receive favorable tax treatment of their policies. This requirement would enhance consumer protection by ensuring that all issuers be required to meet the regulatory standards of at least one state regulatory agency.

3) Public Education. Third, we support a government role in clarifying for individuals the nature, extent, and risks of significant long term care expenses. Many older people are under the impression that Medicare provides coverage for long term care. We need to increase public understanding that Medicare is designed primarily to cover acute care, and that it does not provide adequate coverage for chronic care or non-acute nursing home care. Public misunderstanding on this issue is clearly a major obstacle to the expansion of needed long term care coverage. The recently approved Medicare catastrophic legislation includes a provision that requires that beneficiaries be notified as to what Medicare will and will not cover. We believe this will be helpful to beneficiaries.

4) Data Collection. Finally, we believe the federal government should continue to encourage the collection and availability of cost and utilization data on long term care services. We are pleased that Blue Cross and Blue Shield organization representatives were included in an HHS Task Force which met last year to study how we should gather and organize data on long term care. These data are critical in order to develop effective and sustainable programs with realistic premiums.

We are confident that, with the needed government support, the private sector can increase significantly the number of people protected against the cost of long term care needs.

The Role of Government. The most difficult question Congress must address is the appropriate role for the federal government in the direct financing of long term care benefits. That is, in a public-private partnership for providing long term care protection, who can we expect the private sector to provide protection for and who is appropriately the responsibility of the government?

At the heart of the debate will be the question of whether a new entitlement program should be created to provide long term care or the government should assume the responsibility for individuals based on their financial need. This debate will raise many of the same issues as the debate surrounding the Medicare program in the early 1960's. Based on our experience to date in this market and our extensive experience in the health insurance market, we offer some recommendations for the Congress to consider in this debate.

First, we believe that there should be the greatest possible dependence on private coverage for those who can afford the premiums in order to make federal dollars available for those whose needs the private sector cannot meet. This principle of using private dollars to make federal dollars go as far as possible would apply to either an entitlement program -- for example, an income related waiting period -- or for an entirely means tested program.

Second, long term predictability of government benefits is necessary in order for consumers to plan for their retirement and to feel comfortable purchasing a private policy which they may not use for many years. Long term predictability is essential also for private insurers to design policies that provide good protection.

We are concerned that, unlike the situation with respect to our Medicare supplemental policies, the government cannot count on the private sector using the same "gap filling" model in response to changes in government long term care coverage. Because the nature of long term care policies dictates that premiums be set as much as twenty years in advance of expected benefit use, our ability to adapt our policies if the government reduces or otherwise changes long term care benefits is limited greatly.

We realize that the lack of information related to morbidity, mortality, utilization, and institutional capacity, create inevitable uncertainty as to what benefits the government can or should sustain over time. In addition to these uncertainties, the government faces fiscal pressures separate and apart from the cost of this program which may well create pressures to modify waiting periods or possibly other benefit changes. For example, this could lead to a situation where someone could purchase a two year private policy only to find, when they need benefits, that there is a three year waiting period for government benefits.

This again raises the fundamental question of whether the best basis for dividing responsibility between the public and private sectors is a universal government program with significant cost sharing or whether coordination should be based on each sector assuming responsibility for a defined segment of the population.

Third, we believe that the concept embodied in the recently enacted Medicare catastrophic legislation -- budget neutrality -- is a sound one. In today's fiscal environment, major new programs need to be matched with the revenues to sustain such commitments. Multi-source revenue bases and earmarked taxes are essential.

However, we are concerned that -- in designing a new long term care program as an integral part of the Medicare program -- the Congress give careful consideration to the extent of any additional premium financing from elderly people that may be required. Regardless of whether any new premium would be mandatory or voluntary, there are considerations for either approach. Mandatory Part B premium increases are problematic given the projected expense of Medicare's basic benefits and recently added catastrophic coverage. The supplemental premium for the proposed long term care coverage could lead to a decrease in participation in Part B. On the other hand, a voluntary premium would increase the risk that only those who anticipated using the benefits would participate in the program. If so, the premiums for those participating would be extremely high -- to the point of being unaffordable unless heavily subsidized.

Conclusion

In conclusion, we endorse the basic concept of a public-private partnership as the most promising approach to assuring the availability of long term care services. We believe that more discussion and analysis is necessary to determine whether those who need long term care are best served by an entitlement program that uses a waiting period/deductible approach or an approach that focuses federal dollars on those who do not have access to private programs. We would urge the Congress to move ahead has soon as possible to clarify the tax status of long term care products. And, we again express our concern that it is premature to establish federal standards for the purpose of certifying long term care policies. We look forward to continuing discussions and to working with the Committee.

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Chairman STARK. Our next witness, Mr. Carl Schramm, is the president of the Health Insurance Association of America. Welcome to the committee, and proceed in any way you wish.

STATEMENT OF CARL J. SCHRAMM, PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. SCHRAMM. Thank you.

The current system for financing long-term care is clearly unacceptable. Instead of pooling risks, it places each household on its own and Medicaid becomes the payer of last resort when household resources are depleted. This system, combining out-of-pocket outlays and welfare, features remediation and relief when prevention and planning would be preferable.

Moreover, the long-term care problem is not just a financing one, and it should not be viewed separately from the health care delivery system. Long-term care delivery systems are fragmented and piecemeal; case management models that coordinate and manage costs are still being developed and refined, and there is no guarantee that one model will be appropriate for all communities; the most efficient payment methods for providers are still being tested and evaluated; and data on long-term care service are inadequate for fully understanding the current situation or for making accurate estimates about future utilization and costs.

These significant unknowns should make it clear to both the public and private sectors that more than a funding solution is required. The situation calls for innovation and experimentation on a manageable scale, not a quick plunge into a national solution that fails to recognize how these financing and delivery issues affect costs and access to care.

Appropriate public financing role:

Annual Federal and State spending for long-term care was $24.5 billion in 1985. The Congressional Budget Office has estimated that this figure could increase as much as 275 percent under a fully public long-term care system.

Given today's fiscal realities and competing national priorities, we cannot expect the public to take on such an enormous and unwieldy tax burden. Instead, HIAA believes that public policy should be targeted toward finding ways to more effectively use the private resources already being spent for this care, thereby reducing public long-term care expenditures. Those who can afford to protect themselves should be encouraged to do so.

At the same time, Government should target its limited resources to assist those who can least afford such protection. Private insurance products are not designed for, nor do they lend themselves, as financing vehicles for people who are already quite old, disabled or poor. Providing care for this population should be the objective of public programs, and reforms are needed to improve medicaid's ability to act as a responsible safety net for those who must rely on it.

To this end, the HIAA supports reforms in medicaid such that the program would cover all elderly up to the poverty level, and provide uniform benefits across States, that it would raise the personal needs allowance for nursing home residents, currently $25 a month; and provide adequate reimbursement to providers to assure that appropriate quality care would be provided.

With the hearings of the last year, there has been growing awareness of this problem, and we are happy to report a rapidly developing market for long-term care products in the private sector. There is much evidence of this.

Two years ago, only 16 companies sold long-term care products. This year, we count over 80 companies selling these products. At the same time, much more interest has been developing in the other companies. There has been an enormous change in the underlying product itself. Because of the lack of experience, early products tended to be much more limited, indeed, as has been described by Consumers Union. They covered only short stays in nursing homes, and then only following a hospital stay.

But virtually all of the newer products offered in the last year are enormously expanded. They cover nursing home and home health care stays, often without prior hospitalization. They offer benefits that are triggered on such functional limitation measures as the need for assistance in bathing, eating and dressing.

In addition, some policies are now providing inflation protection against future long-term care costs. We will see a continued trend toward more comprehensive and liberal benefits as private sector insurers gather more and more experience and deal with more and more sophisticated consumers.

The recent introduction of employer-sponsored plans is particularly promising. Such plans offer the opportunity to reach a large number of people efficiently during their working years when premiums are more affordable.

Enrollment experience in group plans to date has shown the average age of the employees electing this coverage is in their early forties. This is strong evidence that with education, younger people can and will purchase long-term care protection. And most of these plans provide coverage to the elderly as well, including retired employees and parents of the worker and worker's spouse.

HIAA believes that private long-term care insurance is evolving rapidly, and that it can play a major role in paying the Nation's long-term care bill. Several factors could hasten this development and strengthen its ability to respond to the public's demand and need for long-term care coverage.

First, we must educate the public. Without understanding the problem, the public cannot be expected to understand the appropriate solutions, let alone even develop itself, the public, as a market for private coverage.

Second, we must improve Medicaid's ability to act as a responsible safety net. The Government must take full responsibility for providing care to those without the resources to care for themselves or to provide—or to purchase private care.

Third, we must consider ways to make long-term care insurance more affordable for the elderly and more attractive to a younger population. They offer immediate help and a better solution for tomorrow.

I believe Mr. Minck will discuss in more detail many of the Federal tax barriers that prevent the development of a fuller market at this point.

Fourth, we must encourage State adoption of the model long-term care insurance bill developed by the National Association of Insurance Commissioners. This protects consumers and provides needed flexibility.

Finally, we must continue to have government support, data collection and basic research on how to finance and delivery care to this population. All of society benefits from activities such as biomedical research and research into chronic illness, and alternative experiments in terms of delivering care.

Thank you.

Chairman STARK. Thank you.

[The statement of Mr. Schramm follows:]

STATEMENT OF CARL J. SCHRAMM, HEALTH INSURANCE ASSOCIATION OF AMERICA

Good morning Mr. Chairman and Members of the Subcommittee. I am Carl J. Schramm, President of the Health Insurance Association of America (HIAA). HIAA represents some 350 insurance companies which write over 85 percent of all commercial health insurance in this country.

We appreciate the opportunity to talk to you about the developing long term care insurance industry. I have submitted, for the record, our publication entitled "Long Term Care: Choices and Possibilities" which describes the state of the growing long term care insurance market and outlines our position on the appropriate public and private sector roles in financing long term care.

Let me begin by summarizing the most important points of our testimony.

- The current financing "system" is unacceptable. The long term care problem is complicated and requires a thoughtful solution, not a rush to judgement.

- Fiscal realities and other national priorities make it irresponsible to place the financing burden primarily on the federal government. All elements of society -- individuals, families, volunteer organizations, employers, and insurers must also play a vital role.

- There is a growing and critical role for private insurance to provide a better means of financing long term care for those who can afford to protect themselves, thereby reducing their reliance on Medicaid.

- There is a continued and indeed, greatly improved role, the government can play in financing long term care for those without adequate resources to protect themselves.

- There continues to be a critical government role, independent of financing care, in furthering our collective knowledge about who will need long term care, what services will be provided, and what the total cost to society will be.

- Many ideas are being proposed for sharing the responsibility of long term care financing between the public and private sectors. But, agreement has not been reached regarding the optimal or "best" arrangement. To hasten the development of an appropriate solution, we support:

    - educating the public. Without understanding the problem, the public cannot be expected to understand the appropriate solutions.

    - improving Medicaid's ability to act as a responsible safety net. The government must take full responsibility for providing care to those without resources to care for themselves.

    - considering ways to make long term care insurance more affordable for the elderly and more attractive to a younger population. Such actions offer immediate help for today's elderly and a longer range solution for tomorrow's elderly who have the time to prefund for their potential long term care needs on an affordable basis.

    - encouraging state adoption of the model long term care insurance bill developed by the National Association of Insurance Commissioners. This bill protects consumers and permits needed flexibility for a developing line of insurance.

- continuing government support for long term care data collection and research. All of society benefits from activities such as biomedical research investigating the causes of chronic illness and national surveys of the long term care population.
- promoting cooperative public-private financing and delivery arrangements on an experimental basis. A comprehensive national policy should be based on a full understanding of the alternatives and their cost-effectiveness.

The public and private sectors must take the time to make the necessary investments in designing a financing arrangement that we can live with today and our children can live with tomorrow.

Nature of the Problem

When we speak of "long term care," we are describing a wide range of medical and support services provided to individuals who have lost some or all capacity to function on their own due to a chronic illness or condition and who are expected to require these services for an extended period of time. About 70 percent of the non-institutionalized elderly with long term care needs receive all their help from family members and friends. However, 30 percent receive additional paid home care services and between 25 and 40 percent of all elderly will spend some time in a nursing home.

Long term care is the major catastrophic health care expense faced by the elderly today. For those elderly who have out-of-pocket health care expenses over $2,000 a year, an average of 80 percent is spent on nursing home care. With nursing home costs estimated to average $22,000 - 25,000 per year, such expenses can indeed cause financial ruin.

The current system for financing long term care is clearly unacceptable. Instead of pooling risks, it places each household on its own and Medicaid becomes the payer of last resort when household resources are depleted. This system, combining out-of-pocket outlays and welfare, features remediation and relief when prevention and planning would be preferable.

Moreover, the long term care problem is not just a financing one, and it should not be viewed separately from the health care delivery system. Long term care delivery systems are fragmented and piecemeal; case management models that coordinate and manage costs are still being developed and refined, and there is no guarantee that one model will be appropriate for all communities; the most efficient payment methods for providers are still being tested and evaluated; and data on long term care service use are inadequate for fully understanding the current situation or for making accurate estimates about future utilization and costs.

These significant unknowns should make it clear to both the public and private sectors that more than a funding solution is required. The situation calls for innovation and experimentation on a manageable scale, not a quick plunge into a national "solution" that fails to recognize how these financing and delivery issues affect costs and access to care.

Appropriate Public Financing Role

Annual federal and state spending for long term care was $24.5 billion in 1985. The Congressional Budget Office has estimated that this figure could increase as much as 275 percent under a fully public long term care system.

Given today's fiscal realities and competing national priorities, we cannot expect the public to take on such an enormous and unwieldy tax burden. Instead, HIAA believes that public policy should be targeted toward finding ways to more effectively use the private resources already being spent for this care, thereby reducing public long term care expenditures. Those who can afford to protect themselves should be encouraged to do so.

At the same time, government should target its limited resources to assist those who can least afford such protection. Private insurance products are not designed for, nor do they lend themselves, as financing vehicles for people who are already quite old, disabled or poor. Providing care for this population should be the objective of public programs, and reforms are needed to improve Medicaid's ability to act as a responsible safety net for those who must rely on it.

Currently, Medicaid eligibility extends to only two-thirds of the non-institutionalized elderly poor. The public sector must recognize and expand its responsibility to this group. HIAA supports the following Medicaid reform measures:

- covering all elderly up to the poverty level and providing uniform benefits across states;

- raising the personal needs allowance for nursing home residents, currently $25 a month;

- providing adequate reimbursement to providers to assure that appropriate quality care can be provided;

- supporting informal caregivers, if available, to reduce reliance on formal or paid providers;

- liberalizing eligibility criteria for Medicaid home- and community-based care to reduce nursing home use;

- removing current incentives that encourage the elderly to intentionally divest themselves of their assets to become eligible for Medicaid; and

- allowing Medicaid spend-down requirements to be modified on an experimental basis in states planning to test public-private long term care financing models.

New Developments in Long Term Care Insurance

The insurance industry is justifiably proud of the role it has played in the evolution of the largest private insurance system in the world. Now, we are entering the next logical phase of this evolution. Advances in medical technology and general health are increasing the lifespan of the elderly, but they are also increasing the number of people who will need treatment for chronic illness. At the same time, rising income, particularly among the elderly, makes insurance against the costs of long term care affordable. The time has come to begin folding long term care into this country's extensive private insurance system.

The market is developing rapidly, as evidenced by the number of companies developing long term care insurance products, the number of individuals covered and the variety of products being developed. There are now about 80 companies selling a long term care product and almost all of this growth is since 1985. Today, there are about one-half million policyholders. Some companies report doubling their number of policies in force each year.

More importantly, the products themselves are changing. Because of the lack of experience, the early products tended to be more limited. For instance, they covered only stays in a nursing home and then only following a hospital stay. But virtually all the newer products offer coverage of nursing home and home health care, often without a prior hospitalization. Instead, benefits are triggered based on such functional limitation measures as the need for assistance in bathing, eating, and dressing. In addition, some policies are now providing inflation protection against future long term care costs. We will see a continued trend toward more comprehensive and liberal benefit provisions as private sector insurers meet the demands of increasingly sophisticated consumers.

The recent introduction of employer-sponsored plans is particularly promising. Such plans offer the opportunity to reach a large number of people efficiently during their working years when premiums are more affordable. Within the last year, seven large employers have offered such coverage. Several more have expressed interest in offering a plan within the coming year.

Enrollment experience in group plans to date has shown the average age of the employees electing this coverage is in their early 40's. This is strong evidence that with education, younger people can and will purchase long term care protection. And, most of these plans provide coverage to the elderly as well including retired employees and parents of the worker and worker's spouse.

Challenges to the Long Term Care Insurance Market

HIAA believes that private long term care insurance is evolving rapidly and that it can play a major role in paying the nation's long term care bill. Several factors could hasten this development and strengthen its ability to respond to the public's demand and need for long term care coverage.

Public Education

The need for better consumer education is the responsibility of both the private and public sectors. It is virtually impossible to sell a product to someone who already believes they have it. However, this is where we find ourselves with long term care insurance. Education should begin early, so that working age people can plan for their potential long term care needs while they have the income to do so.

HIAA has undertaken a number of initiatives in this area. One example is the "Consumer's Guide to Long Term Care Insurance". Some one million copies have been distributed in the last 2 years. HIAA remains willing to work with all levels of government to further similar communication and education efforts.

Information and Research Needs

The development of an effective long term care insurance policy and its appropriate pricing relies on a good body of data. Although insurers are gaining more experience in long term care, the federal government remains the most effective organization for collecting and analyzing data on a large scale basis. Surveys such as the National Long Term Care and National Nursing Home Surveys provide invaluable information to public and private decisionmakers alike. The federal government must continue this important function by providing data in a useful and timely manner.

In addition, more government resources are needed in basic and applied biomedical aging research to facilitate the management of chronic disease and disability. Treatments which ameliorate or control conditions such as Alzheimer's disease, incontinence, and osteoporosis will greatly enhance the quality of an older person's life and significantly reduce the need for costly long term care services.

Lastly, many needs of chronically disabled individuals, such as running errands, doing odd jobs around the house, and enjoying social visits, cannot be expected from a publicly or privately financed program. Our voluntary service sector must mobilize to more systematically meet the needs of a society that will continue to age. The federal government could play a vital role in stimulating these actions.

Combining our collective knowledge, the public and private sectors can move toward the design of the optimal long term care program. Better utilization data are needed. Better strategies for delivering appropriate but cost-effective care must be developed. Better methods for assuring high quality providers through greater numbers of well-trained personnel are needed. And, more basic and applied biomedical research is essential to help identify ways of reducing the need for long term care services. To this end, HIAA supports research and demonstration efforts such as the Robert Wood Johnson Foundation planning grants to the states to develop public-private financing and delivery models for long term care.

Federal Tax Environment

Long term care insurance is a new product with an uncertain status under the federal tax code. In order to stimulate the growth of private insurance, especially employer sponsored coverage, and reduce its costs, the federal government needs to clarify the tax status of long term care insurance. Administrative and legislative barriers to several logical and effective product designs must be removed. These include:

- o clarifying that reserves under long term care policies qualify for the same treatment as life insurance reserves and that increases in such reserves are deductible by the insurance company,

- o giving long term care insurance the same tax status as health insurance with regard to the treatment of premiums paid and benefits received under individual and group contracts,

- o promoting employer sponsorship of long term care insurance as an employee benefit by removing restrictions that inhibit prefunding of retiree benefits and by permitting long term care insurance as a cafeteria plan benefit, and

- o permitting a variety of existing asset accumulation vehicles, such as pension plans and life insurance, to be modified to include long term care options.

In addition, a tax credit for the purchase of long term care insurance, as proposed in Secretary Bowen's catastrophic illness report, might be considered. A tax credit could be especially beneficial for today's elderly who did not have the opportunity to buy private insurance at a younger age when premiums would have been more affordable. While research indicates that as many as one-half of the elderly could afford to buy private insurance, many more could be helped by this type of government subsidy.

All of the above recommendations have been supported by the Congressionally mandated Task Force on Long Term Health Care Policies and Secretary Bowen's report on catastrophic illness. We believe that these incremental actions would encourage private insurance growth and contribute to the ultimate development of a public-private partnership.

State Regulatory Environment

Long term care insurance is a new product that continues to evolve. Insurers need a state regulatory environment which is sufficiently flexible to allow for the development of new and different products but is equally effective in protecting consumers. In December 1986, the National Association of Insurance Commissioners (NAIC) adopted model legislation that successfully balances these two objectives. In the last 18 months, 17 states have passed the model bill and another five are expected to do so by the end of 1988. In addition, five more states have passed legislation or regulations that establish standards equal to or more stringent than the model bill.

We are encouraged at the speed with which states have acted to govern this new product. As an industry, we must minimize the potential for consumer abuses if we are to sustain a viable market. HIAA supports this critical legislation and is working actively in those remaining states for its passage.

HIAA believes that the future direction of long term care insurance -- coverage in the workplace -- offers additional advantages to individuals seeking such benefits. Employers play an important role in selecting the plan and educating their employees about the benefits. These circumstances provide working age consumers more opportunities to gain information and understand potential long term care needs.

Summary and Conclusion

We all agree that solving the nation's long term care problem is vitally important. HIAA believes that the flexibility of private insurance offers the preferred approach to prefunding long term care for many Americans. Private insurance also provides maximum flexibility to informal caregivers. And, over time, we believe private insurance will give millions of people an opportunity to finance their own long term care needs in a way that prevents their impoverishment.

Given this promising start, government budgetary pressures, and many important health care priorities, HIAA believes it would be a mistake to minimize the role of private insurance in designing a comprehensive national policy for long term care. Instead, the public and private sectors must combine their efforts and knowledge to create a solution that will benefit most Americans today and in the future. This investment will pay off many times over as you and I grow older and will help us avoid placing an unsupportable tax burden on our children.

Thank you Mr. Chairman and Members of the Subcommittee. We look forward to working with you to provide further assistance in this area.

Chairman **Stark**. Mr. Richard Minck, the executive vice president of the American Council of Life Insurance, will be our next witness.

STATEMENT OF RICHARD MINCK, EXECUTIVE VICE PRESIDENT, AMERICAN COUNCIL OF LIFE INSURANCE

Mr. **Minck**. Good afternoon, Mr. Chairman and members of the subcommittee. With me is Steve Kraus, the senior general counsel at the ACLI and a leading tax lawyer in this city. We appreciate the chance to testify today on the problem of protecting our older citizens against the cost associated with long-term care illnesses.

To solve the problems, we think close cooperation is needed between the public and private sectors. Our comments today are limited to one aspect of this needed partnership, namely, changes in the current tax laws to permit and encourage the development of products that will provide long-term care protection and will help make it possible for employers to purchase these products for their employees and for individuals to buy such coverage for themselves.

As Mr. Schramm pointed out, initially, long-term care policies were sold on an individual basis; they are now being offered through employer-sponsored programs. Tax laws should be clarified to encourage the more rapid development of this latter type of program, since the purchase of such coverage by employers will permit rapid coverage of a large number of people.

A second recent approach is the use of an individual life insurance policy to provide long-term care benefits. Such benefits are made available by adding a rider on to a life policy which uses the policy's value to provide for long-term care expenses.

In the written testimony, there is an example of a particular life policy and how it works, and we would be happy to respond to questions on it. In order to make it possible for insurers to develop and market successfully other types of long-term care products, there are several clarifications and changes needed in the current tax law, we have identified nine such items.

First, benefits made under long-term care insurance policies should be treated like health insurance benefits and should be excludable from the income of the policyholder.

Second, the amounts paid to an individual under a long-term care policy should constitute payment for expenses incurred for medical care and any premium should be deductible just as premiums for other policies covering medical expenses are deductible.

Third, coverage under a long-term care policy should be allowed as a benefit under a cafeteria plan provision that would permit employees to pay for such coverage with before-tax dollars.

Fourth, contributions made by an employer on behalf of the employees for benefits under a long-term care insurance policy should be deductible to the employer, as is the case with other health benefits.

Five, reserves under long-term care policies should qualify for the same tax treatments as life insurance reserves, and increases in such reserves should be deductible by the life insurance policy. We have four other suggestions that deal with how you would need to make changes to cover the situation where individuals are using individual life insurance contracts or annuities for purposes of financing long-term care.

And we go into some detail in that on the written statement. We support several bills that have been introduced that deal favorably with one or more of the nine issues that we have outlined in our testimony.

The most thorough treatment of the issues is contained in H.R. 4631, a comprehensive bill introduced by Representative Kennelly, and in a bill being introduced by Representatives Gradison and Kennelly, the Long-Term Care Provision Act of 1988.

This latter bill deals exclusively with clarifications and changes in the current tax law of the sort that we feel are needed. We, therefore, strongly support the efforts of Representatives Gradison and Kennelly and others who have introduced legislation to clarify and modify the tax laws that apply to long-term care insurance.

We would certainly be happy to work with the subcommittee to help in any way to develop an appropriate package in current tax law, would go a long way to addressing the question of how do you finance the benefits needed for the older people.

Moreover, the amendments we support, we encourage them to start at younger ages when the price is more affordable, and it will help the employer to provide for their employees, which we think provides the greatest potential for reaching large numbers of people.

Mr. Chairman, thanks for the chance to present our views.

[The statement of Mr. Minck follows:]

STATEMENT OF RICHARD MINCK, AMERICAN COUNCIL OF LIFE INSURANCE

Good morning Mr. Chairman and Members of the Subcommittee. My name is Richard Minck. I am Executive Vice President of the American Council of Life Insurance. I am accompanied today by Stephen Kraus, Senior Associate General Counsel at the ACLI.

I am pleased to testify today on behalf of the American Council of Life Insurance about the critical problem of protecting our citizens against the catastrophic costs associated with long-term illnesses. Due to the rising costs of health care, this problem is becoming a national crisis. The insurance industry believes that the most effective way to solve this problem is through a creative partnership between the public and private sectors. My comments today are limited to one aspect of this partnership: modification of the current tax law in order to create an environment that will permit and encourage insurers to more rapidly develop products that will provide long-term care protection and will help make it possible for employers and individuals to purchase these products.

The ACLI is the major trade association of the life insurance industry, representing 640 life insurance companies. Together, our members hold approximately 94 percent of the life insurance in force in the United States and represent approximately 94% of the assets of life insurance companies.

As Mr. Schramm has already indicated, long-term care is the major source of catastrophic illness expense paid for directly by individuals today, particularly the elderly. About 1.3 million elderly, or four percent of the population aged 65 or older, receive long-term care in nursing homes. An additional 5.3 million receive long-term care in their homes or other settings. The number of elderly needing long-term care is expected to increase by nearly 50 percent by the year 2000, before even the oldest baby boomers reach retirement age.

Long-term care includes a wide range of medical and support services for people who suffer physical or mental disorders causing functional limitation or disability and therefore need assistance for an extended period. The responsibility for providing long-term care assistance ranges from the individual and family to the government through the Medicaid program for those unable to provide for themselves. Private long-term care insurance can assist in providing protection against the catastrophic and mostly uncovered costs of long-term care. As the report to Congress and the Secretary by the Task Force on Long-Term Care Policies of the U.S. Department of Health and Human Services, dated September 21, 1987 states at page 1: "Private long-term care insurance gives individuals the opportunity to retain choices and develop a flexible, planned response to a potentially ruinous event ... Insurance offers the most cost effective, collective approach to meeting financial risks that often devastate individuals."

Although long-term care is an insurable event, lack of experience with respect to the nature and extent of the risk involved has caused insurers to move cautiously and slowly into this market. As Mr. Schramm has previously noted, however, the number of companies developing long-term care insurance products, the number of individuals covered and the variety of products being developed, is increasing rapidly, although the extent of coverage still remains quite small relative to the potential.

An important factor that is inhibiting even faster growth of a private long-term care insurance market is the uncertain tax treatment of long-term care policies to (1) insurance companies issuing the policies; (2) employers who may want to provide long-term care protection as an employee benefit; and (3) individuals who will receive long-term care benefits.

Initially, long-term care policies were only marketed on an individually-purchased basis, but now are increasingly being offered through employer-sponsored programs. Tax laws should be clarified to encourage the rapid development of this latter type of program since its purchase by employers will permit a larger number of people to receive protection against long-term illness more rapidly.

The employer-based programs currently being developed by our industry have a level individually determined premium which is guaranteed renewable. The insurer may not cancel the policy (except for non-payment of the premium) and the individual's premium will not increase regardless of his age or physical condition. If an employer terminates sponsorship or the individual leaves the group covered by the policy, the insurer guarantees that each individual will have the right to continue the coverage provided under the policy at the same premium. Although these policies currently do not contain any cash values, several companies are looking into whether such a product can be developed.

A second approach recently developed by several companies and of great interest to many others is the use of an individual life insurance policy to provide long-term care benefits. This product is significant for three reasons: (1) it allows individuals whose employers will not offer long-term care protection as an employee benefit to provide such protection for themselves in an economical manner; (2) it serves as an interim solution while the group market develops to its full potential; and (3) it allows employees who have long-term care protection as an employee benefit to supplement such protection if necessary. Such a benefit is available by adding a rider on to a life insurance policy, which uses the policy's life insurance values to provide for long-term care expenses. The rider provides for the payment of a certain percent of a policy's death benefit each month the insured requires long-term care. While the benefits are being paid, the death benefit decreases each month by the amount paid. I believe an example of a particular arrangement would be helpful.

Assume long-term care payments begin under a policy purchased by an individual with a $100,000 death benefit and a $10,000 cash value. The first monthly payment equals $2,000 -- that is, two percent of the death benefit. The cash value would also be reduced by two percent so that after the first payment the death benefit and cash value will be $98,000 and $9,800, respectively. Under this particular policy, the policyholder has the option of keeping the cash value in tact by choosing to receive a lower payment of $1,800, resulting in reduction of the death benefit to $98,200 and leaving the cash value at $10,000.

The "cost of insurance" charge for this particular long-term care rider generally equals a certain percent of the cost of insurance charged for the underlying policy itself. Addition of the rider typically results in an increase in the level annual premium payable for the policy over the lifetime of the insured.

In order to make it possible for insurers to market these types of innovative long-term care products successfully, the insurance industry believes that several clarifications and changes are needed in the current tax law:

(1) Long-term care benefits. Benefits paid under long-term care insurance policies should be treated like health insurance benefits, and thus, excludable from the income of the policyholder.

(2) Premiums for long-term care benefits. Amounts paid to an individual by reason of coverage under a long-term care policy should constitute payment for expenses incurred for medical care and therefore any premium for such coverage should be deductible just as premiums for other policies covering medical expenses are deductible.

(3) Inclusion of long-term care insurance in a cafeteria plan. Coverage under a long-term care insurance policy should be allowed as a benefit under the cafeteria plan provisions, thereby allowing employees to pay for such coverage with before tax dollars.

(4) Treatment of long-term care under certain employer programs. Contributions made by an employer on behalf of its employees for benefits under a long-term care insurance policy should be currently deductible.

(5) Treatment of reserves under long-term care policies. Reserves under long-term care policies should qualify for the same tax treatment as life insurance reserves and increases in such reserves should be deductible by the insurance company.

(6) Use of IRA assets, pension payments, or life insurance cash values to purchase long-term care insurance. The use of IRA assets, proceeds from qualified pension or profit sharing plans, or proceeds from annuity, endowment, or life insurance contracts to pay for long-term care insurance should be allowed on a tax-free basis, even though such distributions might otherwise be taxable.

(7) Exchanges of life insurance or annuity contracts for long-term care insurance contracts. Individuals with accumulated cash values in life insurance or annuity contracts should be allowed to exchange such contracts for long-term care insurance on a tax-free basis.

(8) Tax credit for long-term care insurance. Either in lieu of, or in combination with, the exclusion of IRA, pension or cash value proceeds when used to purchase long-term care insurance, a refundable tax credit should be provided for lower-income individuals who purchase long-term care insurance.

(9) Definition of life insurance. It should be made clear that the presence of a long-term care rider does not alter the status of the basic policy as one of life insurance for purposes of the tax law. Also, the treatment of the cost of the long-term care rider should be clarified.

At this point, Mr. Chairman, I would like to make a few comments with respect to the inclusion of cash values in long-term care policies. These comments relate to insurance purchased by individuals, either on their own or under the sponsorship of their employer.

We believe that it is important to expand the market for long-term care insurance to include individuals in their 40s and 50s. By so doing, we encourage a large segment of the population to purchase long-term care insurance when premiums are lower. In effect, we encourage this segment of the population to pre-fund a portion of their long-term care insurance costs. In our view, significant expansion of the market in this way will require that long-term care policies include cash values and perhaps other nonforfeiture values.

For most individuals, the chances of being confined to a convalescent care facility prior to age 65 are remote. Consequently, for an individual who is in his 40s or 50s, most of the premium paid toward a long-term care policy is funding a future benefit. Only a small portion of the premium paid is paying the cost of current insurance. Consequently, in the interest of equity and to encourage the purchase of long-term care insurance, it is reasonable for policies to include a cash value. In this way, purchasers of these policies are assured that monies set aside to fund future insurance costs will be returned if death or some other event intervenes, or if they decide to switch insurance to another carrier taking their cash values. In this way, cash values in long-term care insurance can play the same role as cash values do in permanent life insurance.

We are pleased that several bills have been introduced that favorably deal with one or more of the issues outlined above. The most thorough treatment of these tax issues is contained in H.R. 4631, a comprehensive long-term care bill introduced by Representative Barbara Kennelly and, in a bill being introduced by Representatives Gradison and Kennelly, "The Long-Term Care Insurance Protection Act of 1988." The latter bill deals exclusively with clarifications and changes to the current tax law in order to encourage the development and purchase of long-term care insurance policies. We strongly support the efforts of Representatives Gradison, Kennelly and others who have introduced legislation to clarify and modify the tax law as it applies to long-term care insurance and stand ready to work with your Subcommittee to develop a comprehensive tax package that can quickly be enacted into law.

The problem of long-term care is a critical issue for the nation. Favorable clarification and change of current tax law with respect to long-term care insurance policies will go a long way towards addressing this problem and encouraging insurers to develop an extensive, private long-term care insurance market. Moreover, such action will encourage individuals to purchase long-term care insurance at younger ages when the price is more affordable and will stimulate employers to provide coverage to their employees where the potential for reaching the most people is greatest. Finally, allowing individuals to use current accumulated assets on a tax-free basis to purchase long-term care insurance will help those individuals who have a fairly immediate need for long-term care protection.

Thank you, Mr. Chairman, for the opportunity to present our views. We look forward to working with you and the Subcommittee to develop legislation that will effectively solve the long-term care problem facing us.

Chairman Stark. Dick, let me follow up on that. I suspect that you would agree with me that life insurance salesmen, as a group, are among the most effective marketers of any sales people in this country. Is that a fair statement?

Mr. Minck. Based on my own experience, I think that is certainly fair.

Chairman Stark. There is probably—and this is just my guess—more concern among average Americans for protection of their children and spouses in the event of an untimely death, than there is concern with the idea of going to a nursing home. We have heard from the testimony that most people don't want to go to a nursing home. We know we are going to die. So there is in fact this latent urge to protect our families.

I am going to bet that the average American has less than $10,000 in cash value in their estate. I bet I am not too far off.

Mr. Minck. It probably would depend upon the age of the individual.

Chairman Stark. The average individual.

Mr. Minck. If you include infants——

Chairman Stark. Does anyone know what is in the average estate, how much cash value?

I guess I am saying that if it costs $25,000 to $60,000 for a nursing home, that even with all the might and main in sales talent, we probably haven't encouraged enough Americans to save enough cash value in the unfortunate even they might have to go into a nursing home.

I just want to clarify that. I am not sure I have any objection to allowing people to convert cash value to be used to fund nursing homes. However, I have a hunch it won't be a drop in the bucket compared to the overall size of the problem.

With all the king's horses and all the king's men, from Hartford to Chicago to southern California, we have not encouraged a lot of accumulation of assets to meet the needs of those who might require nursing home care.

Mr. Minck. Mr. Chairman, I would agree with you that certainly one problem is that there are not enough assets for the current generation of older people. However, I think the problem is of such magnitude that everything helps and changing the tax laws to make it possible——

Chairman Stark. No question, and I am not suggesting we shouldn't. I am just trying to say that there is so much more, and that is where I want to get you to help us.

As you know, I am willing to negotiate with the devil himself, but let's assume that you take the top 20, even 30 percent of our group.

We may have to do some things, but let's give you the litmus test. How about supporting mandatory health insurance for all employed people in this country and then extenting that to mandatory life insurance and mandatory long-term care coverage?

Mr. Minck. Again, I would like to respond partially and Mr. Schramm, who is sitting to my right, has responsibility widely in other areas, and I think you would probably get a better and more responsive answer from him.

In the tax areas, one of the things we are asking help for is something that would permit employers——

Chairman STARK. I will support that. What are you going to give me back? Will you endorse mandatory minimum benefits which would include health and long-term care and life insurance?

Mr. MINCK. I think you have come to the part of the question—I would prefer to speak after the Health Insurance Association.

Chairman STARK. I am saying, what do we get in return?

Mr. Schramm.

Mr. SCHRAMM. Mr. Stark, your question really would ask me, in a way, to reorder the universe. Clearly, Mr. Minck asks for consideration of some tax incentives around the life insurance side of things.

I think it might be more useful to think about long-term care as a health insurance employee benefit or individual health insurance policy, in the sense that either in individual form or in the employee group form, which is where the tax inducement might be much more useful, it is not properly thought of as an analogue to the buildup of cash value, but is rather a health insurance system where a number of people are paying in as people are taking out.

As you know, in health insurance there is not the accumulation of assets and so forth; it is money in, money out at the same time.

Chairman STARK. My question is, Would the Health Insurance Association of America support mandatory coverage for all employed persons, given whatever product we decided is necessary for long-term care, with the understanding that we might need some Federal assistance for those who couldn't afford it?

Mr. SCHRAMM. I am not empowered to do anything now except speculate.

I guess if the bargain was good enough that you would compel the purchase of our product in every household in America, we would make some peace with you notwithstanding our inclination historically not to sign up for national health insurance.

My sense is history might be our best guide in the sense that in America we have invented the largest single example of a private insurance mechanism between Blue Cross and our companies. The vast majority of the population is covered, and to the minds of those people covered, covered very well. Every consumer survey shows that.

Chairman STARK. I would like to put some distance between you and Blue Cross, but I will try that in a moment.

I guess I could suggest that we do have to come closer together, because I think it would be a "slam dunk" to provide the health insurance industry and the American Council of Life Insurance the tax concessions they would like.

But in your testimony, Mr. Schramm, what you support is the following. You support educating the public and improving Medicaid, which happens to be under Congressman Waxman's jurisdiction. You support considering ways to make insurance affordable, greater data collection and research, and an experimental basis.

Now, that is not going to help us because the constituents out there don't want any more educating and they don't want any more consideration. They think we have considered too long here. They don't want to have to go into the Medicaid system and they don't want us to do any more research. They want to know why they do not have coverage for long-term care.

What we are going to need is support from your industry on some of the tough issues. Giving you the tax accommodations isn't very difficult, but it is difficult getting your industry to come out and say, "We are going to support some higher taxes on everyone." That is the bitter pill.

We want to hold you to it, so I am going to encourage you to go back to your groups and say, "If we want to play in this"—and you have heard the testimony, a lot of people suggest that there is a big role for private industry in this—"we need some help in getting it."

So, we are going to need your help just like we are going to need the AARP to get the seniors to pay a little more than I think they want to. We are going to have to find ways to get employers, who are your customers, to pay more than they think they ought to.

Mr. SCHRAMM. I don't want us to pass over the issue of education lightly. This market basically didn't exist 3 years ago because there was no public recognition of the fact that medicare didn't cover long-term care.

To illustrate, I just came back from vacation yesterday. I have an 81-year-old aunt who was a high school principal. My mother and her sister are registered nurses, both between 79 and 81, and certainly for their cohort, better educated than average. They did not understand until my aunt was admitted 9 months ago to a custodial care facility that Medicare did not pay, with a son an expert in health financing. Education brought this market into being, and I think part of our offer to the partnership is that there is going to be a robust market for the very large portion of the population who can afford this product. I appreciate your question.

Chairman STARK. If you will promise to blacklist Ed McMahon, Lorne Green, and Danny Thomas from that educational process, which has my mother owning six or seven medigap policies she doesn't need, I will——

Mr. SCHRAMM. God already took care of Lorne Greene.

Chairman STARK. It is the residuals the State is still putting on. My mother doesn't know that.

Mr. Peters, it is my understanding that Blue Cross would in fact, support a Federal entitlement approach to the long-term care problem. Is that a fair way to differentiate you from the other health insurers?

Mr. PETERS. I believe we are entertaining that very seriously in our membership at this time. We have 77 plans across the country. We have a lot of different opinions on this, but we express in our analysis and in our evaluation that a public/private partnership may will need has to embrace that concept.

In what manner—some of the questions this morning were about the definition of entitlement and how it gets expressed in structure—would be very important, but conceptually we may support that.

Chairman STARK. I want to thank Ms. Shearer for being here and for the work that her institution does.

My dream is that we will end up with Consumers Union giving the best advice for establishing standards on private long-term care insurance and the Stark-Gradison bill, and that such members of the insurance industry as Prudential and Blue Cross will support us when we are done, and then we will have done our job right.

Mr. Gradison.

Mr. **Gradison**. Thank you, Mr. Chairman.

I want to thank the panel for their very helpful comments. I am very interested, as I think every Member is, in how we work out this blend of involvement in the public and private sectors.

In my State we can already see the changes taking place in market acceptance of group long-term care plans. Procter & Gamble, which is headquartered in my district, has had a remarkable success in offering a plan where the company doesn't pay anything and where the average age is 40, give or take a few years, of those who have voluntarily signed up for this long-term care benefit.

At the State level, the state retirement systems are, as I understand it, all planning to offer such benefits, again on a beneficiary pay-all plan, to the elderly, to their members starting, I believe, with the State teachers retirement system. It would be interesting to see how that goes, because that should theoretically be the most expensive and toughest market because they are already at high risk because of their age.

It had been my hope that if we properly designed a Government program, and I am not endorsing the Mitchell bill in these questions but using it as an example, that the design of the Federal program would create the market for the private insurance, taking the Mitchell bill as an example, that the 2-year exclusionary period and the 30 percent copayment I had thought would be very appealing because it greatly reduces that tail, the long or expensive stay, the maximum exposure after 2 years would be 30 percent, and yet every insurance company that I have spoken with has expressed substantial reservations about whether something like the benefit approach of the Mitchell bill would have that effect.

I notice in Mr. Peters' testimony a paragraph which I am going to reread to make the point:

> We are concerned that unlike the situation with respect to our Medicare supplemental policies, the Government cannot count on the private sector using the same gap-filling model in response to changes in Government long-term care coverage, because the nature of long-term care policies dictates that premiums be set as much as 20 years in advance of expended benefit use. Our ability to adapt our policies if the government reduces or otherwise changes long-term benefits is greatly limited.

I would be very interested in any of your comments on this. Perhaps naively, although my background is in business and I don't think I approach these necessarily from a naive basis, but I figure that something like the Mitchell bill, while it might cause some companies to stay away from it, would cause enough of them to jump in that others would want to get in, too, lest they lose their share of the market.

I rather thought that whatever you may think of the socializing of a portion of medigap policies with the Stark-Gradison catastrophic bill, I thought that the reality that took 20 years before we did it, would actually be encouraging to the private sector. We didn't step in right away and take away, if you will, from the private sector that elements of the insurance which this expresses some concern about.

I would be interested in your thoughts on this.

Mr. Peters. I believe that this relates just to the uncertainty, the lack of knowledge about this market, about the definitions that may be made by public programs, how those might change in subsequent years regarding financial constraints.

I think the more our people have examined Senator Mitchell's proposals and are in discussion with his staff, the less anguish our staff has. I would repeat that we have many different plans and circumstances across the country who have emerging experience and they will bring that experience and perspective to bear.

We are very openminded to this. We are very concerned that it does relate to the uncertainty of the data, the lack of knowledge of the marketplace.

Mr. Gradison. Thank you.

If there are other comments, I would welcome them. I am just trying to understand what I have been hearing from the industry of great hesitation in this area.

My concern simply is this, that if something like the Mitchell bill, and I only use that as an example, if a benefit structure of that kind were legislated and there wasn't a rather large private sector response to fill the gaps, there is very little doubt in my mind that there would be Government action sometime soon to reduce the 2 years to one and maybe reduce the copayments.

On the other hand, if there were a substantial private sector response as we have had in the private health insurance field, it would be one of the strongest arguments for leaving the thing alone.

I think many believe that the philosophy in politics aside, that the force that has been the most important in explaining the lack of national health insurance in the United States has been the spread of private health insurance, not that it meets all our needs, but that as more and more people are covered by private health insurance, the constituency for a public health plan is diminished.

Mr. Peters. We want to be in it. We want to provide services where the public sector leaves off and creates those opportunities so our philosophical orientation is in that direction.

We have much anxiety in the absence of knowing more about this marketplace but we are not reluctant brides; we will be there.

Mr. Schramm. Inside the association there is a very pervasive debate. The issue is made more complex by Senator Kennedy's offering of yesterday. There is a debate as to which of the two areas, the front or the back ends of the market, is the appropriate place for our attention to focus. We are moving very, very fast but I think the whole question of the unknowns and the rapid development of the interest in the market itself is what characterizes the cautiousness that I think you observe.

Mr. Gradison. Is there any consensus among our members at this time on the front-end/back-end issue?

Mr. Schramm. No.

Mr. Gradison. Thank you, Mr. Chairman.

Chairman Stark. Mr. Schramm, did your association review the Brookings report?

Mr. Schramm. Yes.

Chairman **Stark**. I just wondered whether you had any chance to see how realistic it was. If I read this right, they did some modeling and they are suggesting that for the nursing home benefit, depending on whether it would cost $30, $40, or $50 a month, somewhere between 35 and 45 percent of the elderly would participate.

But as I also read it, they are saying that the percentage of the nursing home expenditures using Medicaid as a model would only run between 7 and 12 percent. Their participation would only allow them to pick up somewhere between 7 and 12 percent of the cost.

If you have any comments on this report, it would be interesting to hear them. Furthermore, separating housing assets from financial assets, they are saying to us that in the age group 65 to 74, senior citizens have, on average, financial assets of $21,000; but in the age group of 75 to 84 that figure drops to around $9,500. Housing assets are roughly double that in each category, so I think we understand their reluctance to spend down.

What I am suggesting in terms of life insurance is that with all the effort that goes into it, we haven't covered the first year. Even if we converted all the life insurance assets in the aggregate to this problem, we still won't make a big enough dent.

I just want to reinforce my plea that if we are going to provide health care coverage with a broad program, we are going to need your help to convince and educate many more people than just your customers. Even though you maintain a very important part of the market, I suspect that as a whole, it isn't a very large percentage.

[The following was subsequently received:]

HIAA

Health Insurance Association of America

Carl J. Schramm
President

August 9, 1988

Honorable Fortney H. Stark
Chairman, House Ways and Means
Health Subcommittee
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

I want to express my appreciation for the opportunity to testify before the Subcommittee last Thursday on the subject of long term care. It is indeed a most important and difficult subject which will stretch us all. However, I want to emphasize our determination to be part of the solution, not part of the problem. Your close attention to our remarks was indeed appreciated and we look forward to working with you in a most positive way.

At the hearing you specifically requested our comments on the Brookings long term care study. Enclosed for your information and the record is a paper we have prepared giving our comments on that study.

Sincerely,

Carl

Carl J. Schramm
President

cc: Ways and Means Members

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HEALTH INSURANCE ASSOCIATION OF AMERICA MAY 1988

HIAA COMMENTS ON THE BROOKINGS INSTITUTION'S STUDY ON LONG TERM CARE FINANCING: CARING FOR THE DISABLED ELDERLY: WHO WILL PAY?

Over the last three years, the Brookings Institution has undertaken the enormous task of analyzing how the nation organizes and pays for long term care needed by the disabled elderly. This study has involved the collection and analysis of a great deal of data and the use of a microsimulation computer model which simulated several public and private financing alternatives to the year 2018. The results of this work are reported in a book to be released May 17, 1988 entitled, Caring For the Disabled Elderly: Who Will Pay?

HIAA believes that the extensive research conducted for this study opens the door for public policy discussion on long term care financing and that the study is both timely and necessary. However, HIAA cannot support the conclusions drawn in this first phase of the study on the limited potential of a private insurance market and the need for a publicly financed long term care entitlement program. At the same time, HIAA looks forward to a continuing dialogue with Brookings' staff as it begins the second phase of the project in which private insurance options will be examined in more detail.

I. SUMMARY

HIAA has concluded that there are several major shortfalls with the study's findings and recommendations.* In summary:

- The study's conclusions on the limited role of private insurance in financing long term care are based on the results of only one of several private insurance options that were tested. Private insurance options that were simulated but produced more favorable results were not included in the study's conclusions. In addition, there was no recognition of the potential impact that newer long term care insurance products could have on the study's conclusions.
- The study's major recommendation, "to restructure and increase federal financing of long term care to provide a more extensive long term care benefit under Medicare" appeared to be based largely on faulty conclusions regarding the limited potential for private insurance. In addition, this recommendation was not supported by a balanced, analytical discussion of public policy efficiency and equity considerations.
- The study's findings and recommendations are based primarily on data that do not change over time. In other words, the model's components assumed constant probability rates rather than recognizing that several factors affecting the long term care population could change over time. Little analysis was presented that discussed the study's limitations in keeping the assumptions constant. Furthermore, little analysis was presented on the range of the model's outcomes that would have resulted if assumptions had been varied about such factors as disability levels, utilization rates, and income and asset holdings.

The policy recommendation that the nation adopt a publicly financed social insurance program is particularly troubling, given that a second phase of this study is now underway that upgrades and refines the model using new data sources and updated descriptions of private long term care insurance policies. There is little doubt that this second phase is absolutely essential to gaining a better understanding of long term care financing issues. However, definitive public policy recommendations for a new entitlement program made in the first study seem to obviate the need for the second phase and, in that regard, appear to be inappropriate.

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* This paper was written before the book's release, but HIAA had the opportunity to review and participate in discussions on several draft documents and interim reports about the book.

Specific problems and questions raised by the study are discussed below in more detail.

II. THE FLAWED PRESENTATION OF PRIVATE INSURANCE

HIAA believes that one of the study's major deficiencies are the conclusions on the limited role of private insurance in paying the nation's long term care bill. We find these conclusions doubly troublesome because: (1) they greatly underestimate the potential role of private insurance; and (2) they form the study's rationale for advocating a new federal entitlement program for long term care.

The Study's Conclusions Are Based on One Private Insurance Option

Although the study tested several different private insurance approaches, key findings on private long term care insurance were predicated on an individual indemnity policy purchased at age 67. This policy provided six years of nursing home care for those meeting a 3-day prior hospitalization requirement (after a 100 day deductible). It was assumed that individuals would buy a policy if it could be purchased with 5 percent or less of their income and if they had at least $10,000 in non-housing assets. Two variations of this insurance option were simulated by the model. The first option had a $50 per day benefit, the second, a $30, $40, or $50 per day benefit depending on what the individual could afford.

Simulating this one type of individual indemnity policy, the following conclusions were drawn:

- By 2016-2020, 26-45 percent of the elderly would be able to afford long term care insurance;
- This insurance, however, would only finance 7-12 percent of nursing home expenditures; and
- Private insurance would only reduce Medicaid expenditures by 2-5 percent.

The study therefore concluded:

> "Even with extremely generous assumptions about who would be able to participate, private sector approaches are highly unlikely to be affordable by a majority of elderly, to finance more than a very modest proportion of total nursing home and home care expenditures or to have more than a small impact on Medicaid expenditures and the number of people who impoverish themselves to Medicaid financial eligibility levels."

Although they were not used in formulating the study's conclusions, three other private insurance options were tested in addition to the one described above. These included a policy purchased at age 30, a policy linked to Medigap insurance and a policy linked to receipt of pension benefits. Looking at the full range of private insurance options tested, the percentage of the elderly for whom long term care insurance would be affordable ranged from 26 to 64 percent in 2018.

This 38 percentage point spread in affordability, depending on input data, is an appropriate and useful finding of the simulations. It shows the sensitivity of the participation rates due to differing assumptions about the type of policy, the age at purchase and the marketing distribution system. Yet the study devoted little discussion and based none of its conclusions on these findings. Therefore, HIAA believes that the study incorrectly drew conclusions without using all of the information available.

The Study's Assumptions on Purchasing the Prototype Policy Are Questionable

HIAA also questions some of the assumptions the study applied to the purchasing behavior of those buying the prototype individual indemnity policy from which conclusions about private insurance options were drawn. These assumptions included: the age of purchase; the affordability of policies; and the type of policy simulated.

The Study Assumes Only the Elderly Will Buy Policies

The prototype policy assumed that only persons aged 67 and older would purchase private long term care insurance, but waiting to purchase a policy until this age makes the coverage less affordable to a significant number of the elderly. Because the lower the age the lower the premium, private insurance must be sold to younger individuals if it is to become an affordable option to the majority of Americans.
Contrary to the assertion made in the study, there is market interest among the younger population. Many insurance companies report that the average age of persons purchasing individual policies has been declining over the last three years, and, more importantly, the average age of employees purchasing this coverage through the work place has been about 40. Clearly, private insurance can be sold to younger people.

The Study's Affordability Assumptions Are Conservative

HIAA questions some of the assumptions the study made regarding affordability of the prototype individual indemnity policy it tested. The policy was considered unaffordable unless individuals and couples could purchase it for less than 5 percent of their income and if they had $10,000 or more in non-housing assets. However, the study did not consider these assets available for the purchase of insurance, but used them solely to identify persons with an incentive to purchase private insurance.

It seems clear that estimates of the potential market for private long term care insurance based on income alone understate the potential demand for these options. Over 85 percent of today's elderly have financial assets such as savings, bonds and other financial instruments that could be used to finance long term care insurance. Over 70 percent of the elderly own their own homes, 11 percent own other rental property and 8 percent own other real estate.

The most appropriate measure of affordability, in our view, would be the amount of discretionary resources available after expenditures for necessities and taxes have been subtracted from combined gross income and assets. Some researchers who have used this methodology have concluded that affordability would be substantially higher than this study concluded. Real wage growth, the higher pension income recipiency under the 1986 tax law changes, and the very high value of real estate holdings of today's elderly all point to increased asset holdings for the elderly of the future.

While the 5 percent of income criterion may be appropriate as a lower boundary of affordability, actual affordability will ultimately hinge on consumer choice and in the case of long term care insurance, the willingness of the elderly to spend assets.

Varying the assumptions about asset levels may not only affect private insurance affordability, it could also affect the rate at which persons who enter nursing homes spend-down to Medicaid eligibility. This critical variable will have a substantial impact on the model's estimate of Medicaid nursing home expenditures and the impact of private sector alternatives on Medicaid. Although the study did not discuss these issues in detail, HIAA recommends that the second phase of the Brookings' study test a range of private insurance alternatives with varying affordability assumptions.

The Study Does Not Test Newer Products

The study concluded that the reason why long term care insurance does not play a bigger role in financing nursing home expenditures was because the products are "flawed in a variety of ways that limit the degree of financial protection they offer". These included: using underwriting tools such as pre-existing condition limitations and health screenings; prior hospitalization requirements; and restrictions on the level of care. However, the study failed to note that newer products provide richer, more flexible benefits that address each of these issues.

Long term care insurance is already available without medical underwriting to large groups of active employees and their spouses. With respect to individual insurance in which medical underwriting must be done, HIAA expects that as insurers gain more experience with long term care coverage, they will be able to insure even higher percentages of those who apply than they do today. This has been the pattern with other insurance products provided by this industry.

The use of a prior hospitalization stay requirement in the prototype policy screened out 25 percent of those using nursing home care from actually receiving a benefit under the policy. This lowered the percentage of nursing home costs which could have been paid for by private insurance. However, most of the newer policies marketed today can be purchased either with or without a prior hospitalization requirement, albeit with a higher premium for the latter. As insurers gain more experience with long term care coverage, HIAA expects this screening mechanism will be used less and less.

Some of the newer policies pay a benefit either in a nursing home or in a home care setting, using an assessment of functional disability based on the inability to perform certain activities of daily living. They do not require a prior hospital stay to trigger benefits. These policies represent the next step forward in the evolution of private insurance for long term care.

The Study Should Test Employer Group Products

The study did not simulate an employer-based, long term care insurance policy. However, it seems clear that private long term care insurance can only reach its full market potential if it is offered through both individual and group policies, particularly employer-based group policies. There are several reasons for this:

- The need for medical underwriting can be eliminated when selling to an entire group (not formed for the purpose of buying insurance) or an employee-based population (except for small groups);
- Administrative and marketing costs are lower for group products;
- The cost of coverage is lower, increasing access to younger buyers; and
- Adequate "prefunding" of future benefits is possible through regular payroll deductions.

Although still in its infancy, a group market for long term care insurance already exists. Interest among large employers in offering an employee pay-all long term care benefit is quite high, as shown in a recent survey by the Washington Business Group on Health. In less than a year, group insurance carriers have written seven employer-sponsored group plans. HIAA expects this number to more than double in the coming year.

These products are being marketed to active employees and their spouses, to parents of both active employees and their spouses, to employees at point of retirement and to retirees. So even in these early stages of marketing employer group products, there are a host of different products and substantial underwriting flexibility. The enrollment data indicate that between seven and 15 percent of active workers are electing the benefit. Considering the newness of the product and the fact that it is paid for solely by the employees themselves, this is a very promising start.

The insurance industry is encouraged by these results and expect that employer-sponsored coverage can reach millions of Americans. The second phase of the Brookings' study can and should expand the range of private options that are examined. These new simulations should also test different behavioral changes that might result from having more extensive private insurance available.

For example, if legislation were passed allowing the tax-free use of asset accumulation vehicles such as life insurance, IRAs, and pensions for the purchase of long term care insurance, HIAA believes private insurance could become more available and affordable. An employer-sponsored group product that trades off some first-dollar, retiree acute care coverage for long term care coverage should also be tested. It is possible that this type of trade-off may become more attractive over time as elderly of the future become both more financially secure and more aware of the lack of insurance coverage for long term care. Lastly, the second phase of the study should extend the model's time frame substantially to determine the effect of private insurance on individuals who are 40 years old today.

III. THE STUDY'S SOCIAL INSURANCE RECOMMENDATION

HIAA believes that the study lacks sound analytical support for recommending a federal entitlement program for long term care. Since this recommendation appears to be the result of premature conclusions about the private insurance market, we believe this public policy recommendation is also premature and is more advocacy than analysis.

The Obstacles to Private Insurance Are Not Insurmountable

Clearly the current "system" for financing long term care must be fixed. Those with the most catastrophic long term care needs should have options other than Medicaid. Both public and private financing solutions face many similar obstacles. These obstacles include prefunding for the expected increases in the future cost of care, providing adequate home care services for the most appropriate population without under- or overserving, and arranging care in the most cost-effective manner through an efficient case management structure.

The study's analysis of private sector insurance options thoroughly examined the above obstacles as they affect the private insurance market. The lack of adequate protection against inflation with indemnity insurance products was one of the most serious barriers to the more effective use of private insurance. The newest policies being marketed today can be purchased with inflation protection. The costs of course are higher. The insurance industry acknowledges that this is a serious problem and one that must be overcome if we are to have a major impact in this market.

However, the fact that these policies are still developing and have not reached their full potential is not a reason to advocate a government entitlement program. Nursing home cost inflation is a major problem for both public and private insurance. Any government program would have to be "indexed" as well and the costs of this program would also be high. The solution lies in controlling health care and long term care costs for both the public and private sectors. Lower inflation rates will help make adequate private coverage more affordable and slow the rate at which individuals exhaust their resources to become Medicaid eligible.

Similarly, the insurance industry is moving rapidly to provide more extensive home care benefits in the belief that home care can be more cost-effective than nursing home care. With this development, insurers have recognized the need for a case management function to assure access to appropriate care. Insurers have a great deal of experience in managing acute care services. In time, they will develop an equal expertise in the long term care area. HIAA does not believe these obstacles are insurmountable.

However, in advocating an expanded Medicare program to cover long term care, little analysis was given to how the public sector would or could handle these problems more effectively than the private sector. In fact, a convincing argument can be made that the monolithic nature of a public program would create an inflexible "one size fits all" solution. On the other hand, private sector options would offer families the flexibility required for the differing long term care needs of individuals and it could adapt better to local delivery systems.

The Study Does Not Analyze Problems with a Public Program

The study did not discuss the limitations of financing the nation's long term care expenses primarily through a public program. The study offered no analysis of the trade-offs in financing a public program through an increased payroll tax versus other forms of public revenues. The study recommended between a 2.2 and 2.9 percent payroll tax, with no cap on taxable salaries, to be shared by employers and employees to finance a program that would cost between $33 and $42 billion.

The study also did not present an analysis on how much alternative public revenue sources could raise or how these public alternatives compared to the cost of such private alternatives as coverage in the workplace beginning at age 40. In fact, HIAA identified inconsistencies in the study's analysis of public versus private sector solutions. A private insurance policy purchased at age 30 was assumed to be unaffordable if more than 1 percent of income was spent on its purchase. However, the study recommended that 2.2 to 2.9 percent of payroll be taxed to finance a public program. Employees would pay half — between 1 and 1.5 percent of that amount. However, the analysis did not explain why a public approach was more affordable than a private one.

Additionally, HIAA does not believe that the nation can afford to allow Medicare to expand to cover long term care. The Medicare Part A Trust Fund will need additional revenues by the end of the next decade and the elderly themselves experienced a 38 percent increase in Part B premiums in 1988. And, Part B continues to rely on ever increasing general revenues for most of its funding. Pending catastrophic legislation would place an additional financial strain on the elderly, especially for those who pay taxes.

Annual federal and state spending for long term care was $24.5 billion in 1985. The Congressional Budget Office has estimated that this figure could increase as much as 275 percent under a fully public long term care system. Given today's fiscal realities and competing national priorities, we cannot expect the public to take on such an enormous and unwieldy tax burden.

Furthermore, like past Medicare expansions, it is very likely that initial estimates of program costs are greatly underestimated. In addition, such federal programs have historically been unable or unwilling to properly pre-fund for future benefits, relying instead on pay-as-you-go financing. Our nation cannot continue to rely on this inequitable model of financing that puts an ever-increasing tax burden on the next generation.

In short, the study's focus was evaluating the role of various public and private financing arrangements which took almost three years of analysis and hard work to produce. However, the study does not appear to have given equal focus or effort to the public policy recommendation which should have been the most critical result of the analysis. As we stated earlier in the paper, advocating a new publicly-financed program appears to obviate the need for the second phase of the study which will examine coverage and affordability of private insurance options in more detail. Only after completion of the second phase can a more thoughtful evaluation of public policy initiatives be undertaken.

IV. LIMITATIONS OF THE MODEL'S ASSUMPTIONS AND OUTCOMES

The conclusions drawn from the Brookings' study stem largely from the microsimulation modeling techniques used to forecast changes to the year 2018. Given the limitations in public and private sector's understanding of who uses long term care and which services are most appropriate, HIAA believes that the model's most useful function should be to highlight the different outcomes that could result from altering assumptions about the future long term care population and relating these varying outcomes to public policy options. This type of sensitivity analysis seems particularly appropriate given the limitations and availability of data that has been used to construct the model.

To be more objective and thorough, the study should have either conducted more sensitivity analysis on the model's major assumptions, or at the very least, discussed in considerable depth, the limitations of the findings given the absence of sensitivity analysis.

The Study's Disability Assumptions Are Not Definitive

Data used to define the long term care population were critical to the model's forecasting of future long term care costs. The Brookings' researchers relied on the best data available to date: those elderly in the community who were identified as chronically disabled in one or more Instrumental Activities of Daily Living (IADLs) or Activities of Daily Living (ADLs) in 1982.

The term IADL refers to needing assistance in such functions as housekeeping, laundry, grocery shopping and transportation. The term ADL refers to needing assistance in such functions as bathing, dressing, walking and toileting. Research shows that persons with ADL impairments generally also have IADL impairments. However, persons with IADL impairments may be free of the more serious ADL impairments.

The model assumed that a limitation in either an IADL or ADL qualified an individual as needing long term care based on the age-sex specific distribution of these limitations from prior national surveys. These disability rates are assumed to remain constant over time.

While these data provided a basis for beginning to define the potential long term care population, further analysis could have been done which varied the disability rate to determine the effects on public and private long term care expenditures. For example, IADL-only limitations were considered as qualifying criteria for public long term care programs or private long term care insurance. How would the model's results have differed if those with IADL-only limitations, fully 30 percent of the chronically disabled elderly in 1982, had not been included in the long term care population? Also, how would the model's results have differed if the onset of disability occurred later in life over the next 35 years given the medical advances that are continuously being made?

In addition, research has shown that several other factors such as marital status, income, and living arrangement contribute to the decision to enter a nursing home. While it may not have been possible to quantify these relationships in the model, some discussion of how these factors affect the size of the long term care population seems warranted.

The Study's Utilization Assumptions Need More Analysis

Another key variable that the model assumed to be constant over the 35-year period was the utilization of long term care services. The model assumed that nursing home beds and home health services would continue to grow at a rate that would accommodate need based on the disability assumptions discussed above. Variation from these utilization rates would have a significant impact on total long term care expenditures and how expenditures would be divided between institutional and noninstitutional care and public and private sources.

For example, data from the 1985 National Nursing Home Survey indicate that utilization has declined 20 percent since 1977. This means that a projection of nursing home use based on the 1985 survey would yield 150,000 fewer beds in the year 2000 compared to the same projection made using the 1977 survey.

A continued constraint on nursing home bed supply through federal and state regulations could also affect future long term care costs. First, nursing home utilization would be reduced, thereby constraining costs. Second, this reduction in utilization might translate into an undersupply of beds that could result in inflationary pressures increasing the cost of care in a nursing home.

The utilization rates of home health services was taken from one data point, the 1982 National Long Term Care Survey and most likely understates future utilization given the growth in third party and out-of-pocket spending for these services.

In addition, home and community-based service use will be greatly affected by the development and scope of case management services. It is likely that widespread availability of coordinated and managed long term care services will increase the use of home care services.

Lastly, no utilization adjustments were built into the model to reflect behavior changes that could result from the various public and private financing options that were tested. The only behavior change the model assumed was a 20 percent increase in home health services that would result from the availability of third party financing under some of the options that were tested. It is also possible that a sudden availability of public and/or private financing to pay for long term care could alter people's perceptions about residing in a nursing home as well as actually altering the services provided in one. Not only might this increase utilization beyond today's levels, but also it would add significantly to the unit cost of care if nursing homes became a more attractive alternative living arrangement.

However, the Brookings' study did not simulate the outcomes of the various scenarios described above. Nor was there much discussion about how these various factors could affect the conclusions that were drawn. HIAA believes that more discussion or analysis of how these various factors could have an impact on the study's conclusions and would have greatly enhanced the quality of the research presented.

V. CONCLUSION

The thrust of the comments in this paper are by no means an attempt to discredit the research or use of the model. The work of the Brookings' staff has been essential in identifying and highlighting areas for further discussion, but HIAA believes that the results, while instructive, should not be considered conclusive .

HIAA also believes the first report will be an influential voice in the continuing public policy debate over the public and private sectors' responsibility for long term care financing. It is HIAA's hope that policymakers will carefully consider the issues raised in this paper in the course of the debate.

HIAA's comments are meant to be constructive in nature with an eye toward enhancing the work of the second phase of the study. In conclusion, there needs to be further research on developing a partnership between the public and private sectors in seeking solutions to the nation's long term care financing and delivery problems.

Mr. **Gradison**. Would you yield?

My understanding of the Brookings study is that they have priced the private insurance policies on the basis of the prevailing premium for individual policies rather than group polices. I think that is a very serious flaw because it will tend to understate the ability of the elderly to buy these policies.

The second point is that I don't think it is entirely accurate to compare the assets that you have mentioned against the cost of nursing home care. I think that should be compared against the cost of the insurance for the nursing home care.

You may recall in some of the luncheon meetings we had where there was discussion of tax incentives for savings for long-term care that one of the principal criticisms of that is that we might be encouraging oversavings since roughly three out of four elderly wouldn't need it because they wouldn't have long-term care expenses of any substantial amount, and therefore that the solution to the problem wasn't a savings solution as such but an insurance solution which might then draw not just on income, but on assets since in a sense we are protecting the assets by development of the program.

I wanted to mention those, particularly the difference in the pricing, because there are problems with the study that we didn't have a chance to go into this morning that have frankly undermined my confidence in some of their conclusions.

Chairman **Stark**. I don't disagree. I just suggest that unless an individual's assets are wildly out of line with the median assets of $20,000, whether they annuitize those assets to buy insurance or you take all the aggregate assets, it still won't be enough.

There simply aren't enough assets to pay one year's cost. So to convert that to some kind of a reserve won't do it.

I suspect that these assets are skewed so that they are accumulated by a fairly small group that these people deal with. I also suspect that this group may be customers for the higher cost care, which runs from $25 on up to $60 per month.

So if you presume that the higher income people are more attracted to the higher cost facilities, then maybe we can strike an agreement with private insurers to help them do what they do best in the segment of the market that they can be expected to best serve. This would allow the Government to concentrate on that area of the market. But you guys don't want that anyway. After all, you can't make any money selling insurance to poor people. I just believe there is an area here for cooperation that would suggest that we each do what we do best, and that is not generally the philosophy that you could sell the members easily, but I think it would make most of our jobs a lot easier.

Mr. **Minck**. The art of forecasting what will happen over the next 20 years is a very difficult one. In 1935, I doubt that anyone could have told you what the private insurance business would look like in 1955. We are at a period where things are just starting in this market, so I think any extrapolation is very hazardous.

The second thing, I would underline the point that Mr. Gradison made that once you get employers involved and it is part of the group mechanism, you may find a very different set of costs and other factors than you have experience so far.

So I suggest suspending judgment a little until another year or two has had a chance to go by.

Chairman STARK. I am very willing to do that if we can include all working people.

Mr. Moody.

Mr. MOODY. Thank you.

Do all of the panelists agree that there should be some Government role here, that the private market by itself will not meet the need? Is there anyone who disagrees that there should be some government role?

There is no disagreement, other than Mrs. Shearer. Do the others of you agree with the thrust of the comments of the Consumer Union report which paints a pretty—scathing may be too strong a word—but pretty critical description of the private sector market at the present time?

Are there any serious reservations about her comments or statements?

Mr. SCHRAMM. I certainly have some. First of all, I just say that, as I said in my testimony, some of what is observed by Consumers Union, is with foundation as regard to products that were assessed as recently as a year ago, and to be sure there are companies selling products that are probably scandalous, and no other word would apply to it.

I think that the products sold by the insurance companies you know about, certainly the current generation of products are products that you would buy in your family and recommend to members of your family to buy, like noncancellable, 5 years' of benefits, inflation proof and so forth. My own sense is that some of that story does not appear in Consumers Union in this particular issue.

I personally am a big fan of what Consumers Union has to offer, but in the portrayal today, insurance companies are even responsible for divorces and that is not the case.

Mr. MOODY. So you are saying that generalization here doesn't reflect some of the better performing products?

Mr. SCHRAMM. That is right. I think it is proper and the union has done a public service to the extent that they cause consumers to become more sophisticated and to be very wary of some insurance products that should not be on the market, but to get people scared off or to become a constituency here of an overarching public program, which is, I think, part of the aim, is ill-advised and without factual foundation.

Mr. MOODY. What kind of a ratio do those higher performing products spend on marketing? One of the points in her testimony is that 40 to 50 percent of premium dollars is expected to go towards these costs.

Mr. SCHRAMM. I would be happy to share that to the extent we can provide it.

One of the things important to note in this controversy is that the next generation of group products is emerging as large cases develop, as in the case of the Ohio and Alaska public employee cases. Obviously, those administrative and sales costs will come down and the force that brought group health insurance into existence will take over.

Mr. **Moody**. To meet your definition of a high-quality product, what would be the minimum percentage of costs for marketing and overhead?

Mr. **Schramm**. I couldn't——

Mr. **Moody**. If one of these better products that you are describing that you feel were not reflected adequately, say, had a 30 percent factor for overhead/marketing, would you consider that acceptable or too high?

Mr. **Schramm**. I couldn't speculate.

Mr. **Moody**. Do any of the others have a threshold definition of a cost-effective private policy?

Mr. **Minck**. To the extent that you are looking at a product that is sold with claims to be paid 20 years from now, it will depend on the flow of premiums throughout that period. Your expenses tend to be at the front of it when you have sales and an underwriting process. It is too early to tell.

Mr. **Moody**. Isn't that true of life insurance? Many of the features of a life insurance policy are the same—you pay premiums over a long period and expect the pay out to come later.

Mr. **Minck**. Within each coverage, there are too many variations among established companies. Going from one line to another, you will just get different ratios.

Mr. **Moody**. Life insurance policies, unless they are dropped, pay out as a certainty, because we all die whereas not everyone needs nursing home care, custodial care or long-term care at all.

Mr. **Minck**. Yes. Again, if you have enough people insured, you can predict with some certainty that there will be a certain number of claims.

Mr. **Moody**. Do all of you—at least all except Mrs. Shearer—agree that tax incentives are an appropriate part of the mix that we might eventually develop?

Mr. **Minck**. Yes.

Mr. **Moody**. Do you think that as a quid pro quo for that there will be tax expenditures and revenue loss, and that there should be Federal standards on the quality of the product?

Mr. **Peters**. Mr. Moody, I believe that the question may be somewhat premature at this point in terms of the definitions that are changing and the work of the NAIC in expanding and changing their definition of standards.

Mr. **Moody**. I am not trying to pick anybody's standard as the standard. I am just asking, if you think there should be accountability in turn for that kind of tax incentive?

Mr. **Peters**. I think some clarity will help. It is part of the education and definition process. Whether those get expressed as standards may be somewhat troublesome because there will be—if the scenario follows—there will be duality, standards in a variety of settings that aren't necessarily matched. That is, different States will have standards, Federal standards, et cetera.

I think that there is a need for some accountability and some clarity so that consumers understand what is available. We are all for that.

Mr. **Moody**. So you are saying as long as there is full information, there need be no Federal standards. I am talking about a Federal tax loss.

Mr. PETERS. You are speaking of the definition of the benefits. I would want to study that question.

Mr. MOODY. All right.

The other gentlemen? Let me say that you said a moment ago that there are some policies that should not be on the market and yet we might be confronted with a situation where we are providing tax incentives for products that shouldn't be on the market.

Should we be in a position of doing that?

Mr. SCHRAMM. My sense is that we could agree to a public scrutiny for preferential tax treatment but the facts are we have already been encouraging public scrutiny. In the last 18 months, 17 States have adopted the NAIC guidelines. Those give the State insurance commissioners the power to exclude policies and hopefully those guidelines will be adopted across the country so these wretched policies will not be available in the market at all.

Mr. MOODY. I am talking about accountability to the Federal standard in return for Federal tax benefits. NAIC, the model bill giving State commissioners power to withhold certain—that is a different issue.

Should there be a Federal minimum standard that is eligible for Federal tax benefits?

Mr. SCHRAMM. It is probably too early. If States accomplish what is needed in terms of performing the role of public scrutiny, I think then the burden would essentially rest on the Federal Government to say that the states didn't protect the public well enough or that the Federal Government could protect the public better. So the answer is no.

Mr. MINCK. I think the answer might depend to some extent on the types of standards involved. For example, I think Mr. Gradison's bill has a few items in it that would require if they could be guaranteed renewable in order to be triggered as the sort of long-term care—those sorts of standards, I think, we are supporting Mr. Gradison's bill.

What concerns everybody in the insurance business, though, I think when you look at Federal standards is that we are directly regulated by the states, and we have been traditionally concerned over the years about the possibility of conflicting regulations between the two levels of government.

Mr. MOODY. Like banks.

Mr. MINCK. Yes.

Mr. MOODY. We know how clear that situation is.

Okay. Anyone else?

Thank you.

This may not be in your direct area of expertise, but there has been a lot of talk about using assets both as an eligibility criteria and as one of the revenue bases. I don't think anyone suggested it exclusively, but one of the revenue bases for whatever public expenditure is involved.

Are any of you troubled by that or do you think that is appropriate?

Mr. PETERS. We have not studied that issue. I can't comment.

Mr. MOODY. Thank you.

Mr. Chairman, I thank you.

Ms. SHEARER. Could I respond to one——

Mr. **Moody**. I should have included Mrs. Shearer.

Ms. **Shearer**. I want to respond and make clear that Consumers Reports looked at what we believe to be the latest policies. We surveyed companies listed in the administration task force report and we gave the companies an opportunity to say: "Actually, we are about to come out with another policy that is even better."

In the case, for example, of Prudential, we looked at two of their policies and one was not even on the market yet. We feel—we closed the books in February—and we feel that we covered what was available at that time.

Mr. **Moody**. You would not disagree, though, with the thrust that the generalizations you have set forth may not be applicable to some of the products that are available?

Ms. **Shearer**. I wouldn't agree. Not one of the policies we looked at was perfect. I am not aware of any policies that would be better.

Mr. **Moody**. Did even the better of the policies that have those kinds of ratios required for marketing and overhead?

Ms. **Shearer**. We don't know the answer to that at this time. I would be surprised if any are much better than——

Mr. **Moody**. The 40 to 50 percent?

Ms. **Shearer**. We don't know. I don't want to say that I know.

Mr. **Moody**. Do any of the members of the panel actually have long-term policies?

Mr. **Schramm**. I do.

Mr. **Peters**. I do not.

Mr. **Schramm**. It is a group plan.

Mr. **Moody**. It is an addendum to a life insurance policy.

Mr. **Schramm**. It is a separate benefit and a cafeteria plan. We pay for it. It is employer sponsored.

Mr. **Minck**. We do not at this point.

Mr. **Moody**. Thank you, Mr. Chairman.

Chairman **Stark**. We thank the panel very much.

Our third panel is comprised of long term care providers: Val Halamandaris, president of the National Association of Home Care; Paul Willging, executive vice president of the American Health Care Association; and Michael Rodgers, senior vice president, American Association of Homes for the Aging.

We welcome the panel to the committee. Without objection, your prepared statements will appear in the record in their entirety, and please feel free, in the order in which I called on you, to summarize or expand upon your statements in any manner you are comfortable.

STATEMENT OF VAL J. HALAMANDARIS, PRESIDENT, NATIONAL ASSOCIATION FOR HOME CARE

Mr. **Halamandaris**. Thank you for the invitation to be here today. We know just how many organizations would like to take up your time, and are grateful for the opportunity.

I would like to commend you for the record that you have established in the months that you have been chairman of this committee. I think few people can claim that kind of record in such a short period of time.

Third, I would like to commend Mr. Gradison in particular for his sponsorship of the hospice legislation. I believe this was a wonderful piece of work. At the time I disagreed with some of the decisions that you all made, but you were correct and I was wrong. I would like to commend you for that.

I would like to say that please don't mistake my enthusiasm for believing that I am always right. I am not. There are cases where I am wrong, and this is one case where I was.

I do believe long-term care is a major problem. I think there is a consensus that we need to do something about it. I think the American public has clearly indicated that through the Harris poll conducted and released earlier this year. Eighty-three percent of the American public believes we ought to do something now.

It is clear to the American public that you gentlemen are going to make something happen. It is a difficult thing for us to do. The choices are very hard. The question of financing ultimately is the real rub to the problem. How do we do it? I think the answer here is a self-evident one, but it may not be one that we want to face.

When it comes to financing long-term care the problem is so large you are going to have to come up with money wherever you can find it, and that means that we will need to have the Federal Government pay a significant share. Individuals probably are going to have to share as well.

I think that the suggestion that was made, that Congressman Pepper made, that we remove the cap on Social Security, was a good one provided that you couple it with the fact that you provide Americans who are in this higher income bracket with the protections that the rest of us receive. In other words——

Chairman STARK. If you would indulge us, I believe, that is the last vote of the day. So if you will give us 5 minutes, we will vote and come right back. We will recess for 5 minutes.

[Recess.]

Chairman STARK. Thank you for your patience. Please begin again.

Mr. HALAMANDARIS. Thank you, Mr. Chairman.

The point that I was making is that we believe there ought to be a Federal entitlement program and not a means tested or welfare program.

These Americans are going to be paying more than their fair share of any program that we structure, and therefore it is appropriate that they also benefit from whatever program we structure. We are going to need money from a lot of different sources and all of us need to contribute to that.

I think another significant point is that we need a substantial state contribution. You can't leave the States out.

We believe that the real issue in long-term care is not age, but functional disability. I agree with you, Mr. Chairman, that we ought to look real hard at including chronically ill children and the disabled in whatever benefits we provide, and it should not simply be another benefit for the elderly. I think if we do that, there is going to be a generational backlash.

We believe that any long-term program should be based on the provision of home care services and then provide nursing home care where appropriate. We agree that both are needed. You can't have one without the other.

I would like to commend your efforts and in closing, I would like to say that none of us interpreted your vote on the Pepper bill, either one of you, as something negative, but rather I believe you were saying we want an opportunity to help and to make things better.

I think you will come up with a program that will benefit the American people, and all of us in the end will be grateful.

Thank you.

Chairman **Stark**. Thank you very much.

[The statement of Mr. Halamandaris follows:]

STATEMENT OF VAL J. HALAMANDARIS, NATIONAL ASSOCIATION FOR HOME CARE

Mr. Chairman and Members of the Committee:

My name is Val J. Halamandaris. I serve as President of the National Association for Home Care (NAHC). NAHC is the largest professional organization representing the interests of home health agencies, homemaker-home health aide organizations and hospices, with approximately 5,000 members. NAHC is committed to assuring the availability of humane, cost-effective, high quality home care services to all who require them.

We appreciate this opportunity to address the issue of long-term care, because the majority of patients our members serve are the frail elderly who are most at risk of needing long-term health care services. We would like to commend you, Mr. Chairman, and this Committee for holding this important hearing and taking action to address the vital issue of the long-term needs of the American population.

1. The Need for Long-Term Care Coverage.

A fundamental health care need of elderly Americans is coverage of costly care required for chronic conditions. Currently, 80 percent of the cost of all catastrophic illnesses relates to long-term care, and there is very little in the way of help from the public or private sector. The cost of a long-term illness is enough to bankrupt even the wealthiest Americans.

Millions of Americans are victims of illnesses of long-term duration. Three million Americans have Alzheimer's disease. Five million Americans have cancer. One and one half million Americans suffer heart attacks each year. 500,000 Americans have Parkinson's disease. 500,000 Americans suffer strokes each year.

The bulk of the care needed by these people is custodial and costs can be staggering. The average American family simply does not have the resources to pay for long-term care.

Neither public nor private insurance provides protection against the costs of long-term care. Medicare pays only for limited amounts of skilled care and home health care. Medicaid generally pays only for nursing home care and requires pauperization before eligibility. Most private health insurance provides limited, if any, coverage for long-term care in the home or in a nursing home. New specialized long-term care policies are expensive and riddled with limitations.

A 1986 report by the General Accounting Office entitled, "Medicare, Need to Strengthen Home Health Care Payment Controls and Address Unmet Needs", analyzed data from the 1982 national long-term care survey and found that millions of seniors are going without the care they need. According to the 1982 data, an estimated 3.2 million seniors needed regular assistance to stay in their home. They needed help in performing such functions as eating, dressing, preparing meals, getting in or out of bed, and going to the bathroom. Of this number, only 1.9 million claimed to have the support they needed.

Although the recently-passed catastrophic health legislation provides for a richer acute care benefit and specifically, expanded coverage of daily services allowed under the definition of "intermittent care" to up to 38 days, the Medicare home health benefit still does not cover all acute care needs, nor any chronic care needs.

2. The Need For Action On A Federal Level

The Federal government must take the lead in providing adequate coverage for long-term care needs. The private health insurance industry has made some efforts to cover long-term care, but the policies which currently exist are few in number and are riddled with exclusions and limitations. To the extent that policies exist, they typically pay indemnity and not service benefits, and their coverage is limited to nursing home care or includes minimal home care provisions. A May 1987 report by GAO identified serious limitations to most long-term care policies:

o Failure to index benefits for inflation: The major deficiency of indemnity benefits, such as those offered in nearly all long-term care policies, is that they pay a fixed amount for a service. That means that the policy may pay $35.00 for a home visit by a registered nurse in 1988 and the same amount in 1995, regardless of how costs have changed.

o Limitations on renewability: Usually the insurer retains considerable discretion as to whether the policy can be cancelled for reasons other than nonpayment of premiums. Even where renewability is "guaranteed", insurers may demand large increases in premiums as the policyholder ages, or may simply not renew the policy for certain categories of persons who are most likely to need the services.

o Prior hospitalization requirement: The GAO survey found that the vast majority of policies surveyed required a prior hospital stay before nursing home benefits would be paid, and many required prior hospitalization for home care benefits as well. However, if our understanding is correct, Mr. Chairman, your recently introduced legislation, H.R. 5085, would help address this issue. Such restrictions severely limit the coverage available under these policies. These limitations made insurance benefits in such policies even more restrictive than Medicare, which does not require prior hospitalization for home health benefits.

o Exclusions for coverage of mental and nervous disorders: These exclusions have important implications for long-term care insurance policies, where more than half of all nursing home residents may have Alzheimer's disease. Policies with such exclusions would not meet the needs of these patients. Moreover, even where policies cover mental or nervous disorders, diagnosis may be difficult when insurers require mental disorders of organic origin to be diagnosed only by a brain biopsy or an autopsy.

o Focus on skilled nursing care: Many policies require that nursing home care be skilled and that home care services be patterned after the Medicare model, i.e., a range of services, including home health aide services, available only if the patient needs skilled nursing care or another skilled therapy (such as speech therapy, physical therapy or occupational therapy).

Given the cost of a comprehensive long-term care policy and the associated risks, it is not likely that the insurance industry will be developing such a policy within the forseeable future. The problem of long-term care requires a national approach to provide a basic range of services, which can be supplemented by the private sector.

Establishing an appropriate Federal role in long-term care would decrease financial pressures on states' Medicaid programs. It would also avoid the disgraceful situation in this country where the elderly are forced to impoverish themselves in order to obtain Medicaid coverage for their long-term care needs.

The Brookings Institute, in testimony provided to the Senate Budget Committee in March of this year, also concludes that the most straightforward approach in federal financing of long-term care is adding long-term care benefits to Medicare, with a corresponding increase in contributions to the Medicare trust fund.

The American population favors a federal program to provide long-term care in the home as well. A recent national poll conducted by Louis Harris and Associates shows that 8 out of 10 Americans favor strong federal involvement. Support for such a program was shared by Americans of all ages and bridged all political and regional differences. 82 percent of those responding said they could not afford to pay for costs of providing long-term care either in the home or in a nursing home. 78 percent of Americans polled said they preferred to receive long-term care in their homes over long-term care in a nursing home. And indeed, only 22 percent of the disabled elderly were in nursing homes in 1985. Over 7 in 10 Americans support a specific tax, such as eliminating the $45,000 cap on income subject to the 1.45% Medicare payroll tax to finance such a federal health program. This method of financing is supported by Americans of all ages, professions and income levels, including fully 73 percent of those earning more than $50,000 and therefore subject to the increased tax.

3. Elements Of A Long-Term Care Program

NAHC believes that the foundation of any long-term care legislation should be home care. Prevention of exacerbation of an illness helps prevent a beneficiary from requiring costly inpatient acute care. Only when home care is inappropriate should Americans break up families and place seniors in a nursing home. Long-term home care would postpone the need for institutionalization until such time when constant care is necessary for the patient's well being.

Long-term home care improves the quality of life because it is more humane. When care is delivered in the home, the patient is surrounded by his familiar environment and support systems which enables his condition to be sustained. Home care is usually more cost-effective. New York State's experience with the Nursing Home Without Walls program is that even the most intensive services can be provided to heavy care patients with excellent results for roughly half of the cost of similar services in a nursing home.

Eligibility should not be contingent upon income, but rather need, nor should it be contingent upon prior receipt of nursing home or hospital services. We have concerns with regard to a beneficiary deductible and/or co-pay, which could affect access to services.

Elimination of the intermittent and part-time definition for nursing services is necessary since the patient's needs are long term.

NAHC believes a long-term care package should include a range of skilled professional services, such as skilled nursing, physical, speech, occupational, and respiratory therapies, nutrition, and social services. Professional assessment, evaluation, and treatment of patients with long-term chronic conditions is not now covered and would be essential for a long-term home care benefit. These services can anticipate and act on symptoms that indicate exacerbation of an illness upon the physicians recommendations.

A home-health aide benefit is necessary to provide personal care (hands on) services, by a trained and qualified individual, which enables a patient to remain clean, fed, and cared for. These caregivers learn to recognize and report symptoms to the registered nurse which indicate an exacerbation or potential complication. In addition, they can sustain a patient's mobility by providing trained exercise regimens. This is the primary service which addresses activities of daily living. It should be clear that this service should never be provided without supervision and patient assessment by a registered nurse.

A long-term care program should also offer respite care (companion, homemaker) services that provide well deserved and necessary relief to supportive caregivers.

We feel that there should be elimination of the homebound definition that restricts a patient from necessary services that keep a person in the mainstream of life. Attending an adult day care center occasionally or regularly can provide professional and social interaction, again to assist in sustaining the patient's condition.

Additionally, benefits such as emergency life response systems should be included. Such a program should also offer education to help teach families how to care for their loved ones.

NAHC would like to see a long-term care program that is geared to functional disability rather than age. Many young families face destitution through the costs of caring for their chronically ill and disabled children and adults. There is currently a strong bias toward placing and keeping chronically ill children in the hospital and adults in nursing homes.

The following is an example of a patient in need of long-term care services who can not receive such services at this time due to policy contraints:

> He is an 80 year old male with Alzheimer's disease who has lost the ability to know when he needs to feed himself, take medications and bathe. The physician has ordered a variety of medications that allow him to sleep and for the treatment of several medical ailments. He becomes lethargic and disoriented because he has mixed up his medications. The skilled nursing visits initially assess the problem areas, develop a plan to assist him with activities of daily living (home health aide visits) and provides a detailed plan to monitor his medication regimen. After a plan is put into action, which may also include daily visits by a family member or neighbor, the nurse may need to visit only once a month while a home health aide visits twice a week.

We believe that past experience with the Medicare home health program supports our view that home health agencies could play a useful patient advocacy role. Although a long-term care program is an entirely new benefit in an area where there is currently little financing, much of the infrastructure is already in place. There are currently 12,000 home health agencies providing care in the home with much case management experience. By making a long-term care program part of the existing Medicare program, the conditions of participation, newly strengthened by OBRA 1987 and appropriately modified by a new long-term care benefit, would apply to home health agencies.

Utilization management would be an essential feature of any long-term home care program. The numerous demonstration projects that have been conducted to develop long-term care programs and the few private insurance organizations that have actually put a long-term care policy into effect seek to control utilization through the use of "case management." *

Typically, a case manager assesses prospective home care patients to determine their strengths and weaknesses for independent living and determines whether home care or institutional care is appropriate. Because of the potential for conflicts of interest and the long-term nature of the care plan being decided on, third parties are reluctant to leave case management entirely in the hands of the home health agency that is providing paid services. On the other hand, it may not be practical for payors to establish and staff case management systems of their own. One major drawback is the substantial costs entailed in duplicating activities that a home health agency would have to carry out in any event in order to care for the patient.

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* OBRA '87 requires the Secretary of Health & Human Services to conduct four demonstration projects to provide case management services to Medicare beneficiaries witih selected catastrophic illnesses, particularly those with high costs of health care services.

In addition, when a third party assumes some degree of responsibility for case management, it usually has to function with a limited amount of information -- less in most cases than is available to the caregiver since the information usually comes from the providers "second hand". Also, a generally accepted uniform assessment has not yet been developed. In any case, third party opinions about informal caregiver availability, medical and nursing needs, and the safety of the home environment can become vague and sometimes quite incorrect.

We believe that the division of responsibilities between payors and home care agency providers should recognize the payor's obligation to protect the program against overutilization and excessive costs. At the same time, the primary responsibility for managing the care of the patient, and serving as the patient's advocate, should be left in the hands of the home care agency. It is the agency caregivers who are trained for assessments, and are in personal contact with the patient on a continuing basis and who are responsible to the patient for his care.

We believe that a balance can be achieved in which the provider remains responsible for case management and the payor can carry out its utilization management responsibilities without an unnecessary, costly and administratively burdensome duplication of patient care planning and review functions. For example again, New York State's highly successful Nursing Home Without Walls program has made use of joint assessment visits by professionals representing provider and payor. A prior approval for the utilization of services after an assessment has been done by the home care agency who provides a plan of care could also serve as an effective safeguard.

Any home care proposal should allow for adequate reimbursement reasonably related to the services provided. If the fees for some types of services or classes of patients are profitable while others lose money, patient care could suffer. This would disadvantage the patients that need certain services and threaten the financial stability of agencies that would choose nevertheless to provide those services.

We are anxious to review the results of Congressionally mandated studies relating to home health prospective payment. OBRA '87 required the Department of Health & Human Services to provide for a demonstration project to develop and test alternative methods of paying home health agencies, specifically that of a prospective payment system. An interim report is due in April, 1990. A second project NAHC is concerned about is a study at Georgetown University, initiated by NAHC, to develop a system for classifying home care patients according to their home care needs. The project is currently under a HCFA contract with a final report due within a year and a half.

Finally, it is important that there be a clear and definite distinction between the current Medicare home care benefit and a long-term home care benefit. Discharge from the current benefit and eligibility for a long-term home care benefit should be established. We recommend that skilled professional services and paraprofessional services that focus on acute medical and nursing needs, whereby treatment is short term and corrects the problem, be the Medicare and third party payor guideline for current coverage. A long-term home care benefit would focus on the patient's long term skilled and paraprofessional needs where the care is not to correct the exacerbating problem but to watch and prevent the illness from requiring institutionalization.

CONCLUSION

Mr. Chairman, we appreciate the opportunity to be here today and discuss this vitally important issue. We look forward to working with this committee in ensuring that meaningful long-term care legislation is enacted. We commend you for your leadership in the area of long-term care.

Chairman STARK. Mr. Willging.

STATEMENT OF PAUL R. WILLGING, EXECUTIVE VICE PRESIDENT, AMERICAN HEALTH CARE ASSOCIATION

Mr. WILLGING. Thank you, Mr. Chairman.

It is a pleasure to be able to testify before this committee today in the area of long-term care financing. I commend you for having begun the long, tortuous analytic process wherein eventually we will reform the financing of long-term care in this country.

Obviously the time is ripe, particularly so given the recent catastrophic financing bill which left graphically untouched the true catastrophic health care experience for most elderly Americans, which is not physician care or hospital care but clearly long-term care. Eighty percent of the catastrophic expenses incurred by the elderly are for nursing home care.

I think perhaps we have an even more parochial reason for supporting change in this regard, and it has to do with the quality of care in nursing homes. It is unfortunate but too often the case that as long as nursing home care is primarily financed out of tax revenues coming from strapped states and their welfare programs, the quality of care provided in long-term care is too often a function of a state's precarious fiscal position and not in fact a function of what is best in terms of the services provided to the elderly.

So we clearly do support dramatic, revolutionary reform in the financing of long-term care. We do support a Federal/public/private partnership. I agree, more often one finds when people are discussing the private/public partnership, they have already made up their minds as to whether they want mostly public or mostly private. We do in fact think that there is a clear role for the individual to be augmented or supplemented, if you will, by a Federal role as well.

We would, however, point to what we think are seven critical issues that should be dealt with in the enactment of legislation. The first has been dealt with to some extent today, a dedicated funding source.

The industry I represent certainly doesn't want to move from the frying pan of funding source which is subject to the annual prices of budgetary deliberations to the fire of yet another public funding source which brings with it the same problems in terms of inadequate attention to the needed resource.

We think analogous to that, the question of rates to be paid under any program has to reflect the need for quality care and not simply what is available in terms of scarce state taxation and resources. We think the individual deserves a choice.

A day of care will, as is more often than not the case, relate more to the minimums required than to in fact the differences that could be accounted for in a nursing home. A nursing home is not a hospital where an appendectomy is an appendectomy. A nursing home is as much a home when the nuances, the variations in terms of environment, climate and the like are critical to individuals, and individuals should have choices to purchase something above and beyond a basic day of care.

The role of the private sector is critical. The Government should not attempt to assume the costs of all long-term care provided to individuals. There should be exclusionary periods and cost sharing; otherwise, the bill will become so burdensome as to forestall the day when we eventually see this change.

We think there probably, during exclusionary periods, is a role for long-term care insurance, and support many of the recommendations made by the previous panel as far as changes in the Tax Code and that relationship to long-term care insurance. We think the protection of the consumer is critical.

We commend you, Mr. Chairman, for H.R. 5085, and that first attempt to make sure we don't see in this area the abuses that led to the Baucus amendment as far as medigap insurance is concerned.

I think we might—and I realize this is not in the jurisdiction of this committee—look at the same type of changes in the Medicaid program. There is no reason that as we change the financing under medicare to account for long-term care insurance, particularly with respect to the poor, that we can't make changes in the Medicaid program as well.

We do not have to countenance constantly a two-tiered system, one for the poor under medicaid and one for others under a different financing forum. Why not change the Medicaid program to allow the medicaid program to pay insurance premiums for the poor with Federal financial participation during whatever exclusionary period might be appropriate.

That concludes my remarks, Mr. Chairman. We look forward to working with you and Members of the committee staff as we move on to what will clearly be an intriguing, dynamic change in terms of financing long-term care.

Thank you very much.

Chairman STARK. Thank you, Mr. Willging.

[The statement of Mr. Willging follows:]

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LONG TERM CARE INSURANCE

by

Paul R. Willging, Ph.D.

before the

SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

August 4, 1988

A non-profit organization of proprietary and non-proprietary long term health care facilities dedicated to improving health care of the convalescent and chronically ill of all ages. An equal opportunity employer.

Mr. Chairman and Members of the Subcommittee, I am Paul Willging, Executive Vice President of the American Health Care Association (AHCA) the largest association representing the nation's nursing homes. AHCA's membership exceeds 9000 long term care facilities which care for about 900,000 nursing home patients each day. As providers, our members routinely deal with the inadequacies of our current long term care financing system and the systematic impoverishment of the elderly in the event that they need long term nursing home care.

Mr. Chairman, I would like to commend you and the members of your subcommittee for your leadership in initiating a comprehensive look at long term care insurance. Your hearings will bring much needed attention to the failure of current financing programs to meet present needs, to the hardships which individuals and their families face in trying to provide or pay for long term care, and to the role that insurance can play in solving some of these critical problems.

First, and foremost, we must acknowledge that we are here today to address a human need, that is, to provide a service to individuals at a time when they are most dependent upon others. Each individual's needs are different, and it is our mission to create federal long term care policies that allow for the dignity, freedom of choice, and self respect that each of us want for ourselves.

Hopefully, these hearings will call attention to the fact that long term care is a normal risk of growing old that needs to be anticipated. Roughly, one in five of us will enter a nursing home in our lifetime. Half of that group will incur extended care expenses for a period that exceeds 90 days. Tragically, however, most elderly and their families are unaware of their personal risk until nursing home care is needed. Recent data compiled at Harvard and Blue Cross and Blue Shield of Massachusetts indicate that 63% of the well elderly 66 years of age and older living alone would become impoverished within 13 weeks if nursing home care was needed. For married couples, one in three would be impoverished after 13 weeks if one spouse entered a nursing home -- leaving the other spouse at home well below federal poverty guidelines.

Clearly, there is a lack of comprehension on the part of many individuals about the financial risk they run in the event they need long term care. Unfortunately, most elderly erroneously believe that Medicare will pay for nursing home care. However, Medicare coverage is almost totally restricted to acute episodes of care, and private insurance coverage has been extremely limited. Of the nation's nursing home expenses, Medicare covers less than 2%, and private insurance less than 1%. Only Medicaid provides unlimited coverage for custodial care in a nursing home, but only to low income persons or those who have exhausted their own resources.

Without losing sight of our ultimate objective of providing quality care we must next ask ourselves, who will pay for these services? How will we pay for them? The problems of financing long term care have been well-documented, and the need for financing solutions grows ever more urgent as the population ages. Yet the financing of long term care continues to be an unresolved national crisis. Catastrophic legislation recently signed into law has focused on acute health care expenses, leaving the elderly exposed to the principal cause of catastrophic expenses by the elderly -- the risk of nursing home care.

The nursing home industry is enthusiastic about the mandate in the catastrophic legislation that creates a bipartisan Commission on Comprehensive Care and sets an agenda for research on the delivery and financing of long term services, and tax policies to encourage the private financing of long term care.

Recognizing that neither the private, nor public sector, alone, can meet the nation's rapidly growing need for long term care financing, AHCA strongly supports a comprehensive public/private financing approach. Programs based on a partnership would foster individuals' independence and personal responsibility, yet ensure that all elderly will obtain long term care with dignity. While a comprehensive system could be developed in many ways, a full range of service alternatives should be made available through the private marketplace. Other sources of financing should be utilized to offer the growing aged population a range of coverage that truly matches their long term care needs.

Private insurance is a promising, but largely untapped solution to our long term care needs. When combined with a variety of public and private resources, it offers protection that neither sector can provide alone. We believe that Congressional action to encourage private insurance is essential to further market development and to realize its full potential in the financing solution. In a relatively short period of time, the number of companies selling long term care products has reached over seventy. The number of policies in force is now estimated to exceed one-half million, double that of just two years ago.

Accompanying the rapid expansion of the long term care insurance market is an overwhelming number of policy options, uncertainties regarding product pricing, benefit limitations, and risk controls. Medical advances, declining mortality and disability rates and inflation make a moving target out of definition of the risk pool. Some standardization of the range and variety of benefit options will inevitably have to take place to facilitate both public acceptance of the product and industry management of costs. Private efforts alone can neither solve the problem of financing extended care services, nor ensure access to care. The problem is too big and growing far too rapidly for the private sector to be able to shoulder the burden alone. Government must encourage, support and complement private efforts.

Some insurers are viewing long term care from a broader perspective than strict medical need or site of service delivery and thus offer more flexible benefits along the long term care continuum. Others are offering managed care, prepayment, group products, and the integration of long term care coverage into existing health and retirement benefits. We view these as positive changes which should be further developed and replicated throughout the industry.

Changes must be made to provide protection for those needing long term care as well as to encourage the elderly to purchase long term care insurance. One approach would be a modest Medicare long term care benefit to be supplemented by private insurance and other resources. Under this approach, Medicare would cover long term care only after a high dollar deductible or a long, time-based deductible period were met. Prior to that point the individual would be responsible for all coverage--either through private insurance, tax preferred cash accumulation instruments such as IRAs, or other personal resources.

Such an exclusionary period, conceivably up to two years, would provide a strong incentive for individuals to purchase private long term care insurance to fill their identifiable coverage gap. It also has potential of encouraging insurers to offer products because their risks would be definitive and limited in time, leading to lower-priced insurance premiums which would be affordable to a much greater proportion of the elderly. According to a recent study by the Brookings Institution, nearly 70 per cent of the elderly would be able to afford a limited long term care policy. A "stop loss" approach such as this would also provide truly catastrophic coverage by stepping in with federal assistance only for those who incur major long term care expenses.

Whether or not this or a similar public/private program is adopted, from the perspective of nursing home care providers, there are several issues that should be addressed in an expansion of Medicare to cover long term nursing home stays.

DEDICATED FUNDING SOURCE

We support the creation of a separate trust fund that would be funded by a combination of an increase in Part B premiums, the lifting of the income tax cap subject to the 1.45 per cent Medicare tax, and an increase in estate and inheritance taxes. Dedicated funding is critical to avoid the need for future financing from general federal revenues. We feel the concept of funding through a payroll tax is consistent with the concept of long term care Medicare coverage as a social insurance program rather than a welfare program.

MEDICARE RATES SHOULD REFLECT THE COST OF THE SERVICE PROVIDED

We feel that any reimbursement system used for long term care providers must be adequate to ensure that providers can provide quality care. We must avoid the problems inherent in many state Medicaid programs in which nursing home rates are more a function of state budgetary pressures, than a reflection of the cost of providing adequate care. We strongly support a prospective payment system that recognizes the needs of the patient and the legitimate costs incurred by facilities in providing care. AHCA has been very supportive of prospective payments for nursing home services; we have worked toward expanding prospective reimbursement that is available under current law for certified skilled nursing facilities that provide fewer than 1,500 Medicare patient days. We would urge that you consider a prospective payment plan, with input from the industry, that would provide for appropriate variations based on patients needs, historical cost structures, and regional wage rates.

ADDITIONAL SERVICES FOR PURCHASE BEYOND THE SCOPE OF THE PUBLIC PROGRAM SHOULD BE AVAILABLE

Some clarification needs to be made in the existing regulatory framework that individuals may purchase additional services in a nursing facility that may not be covered under the Medicare reimbursement rate. This issue was addressed recently in the nursing home reform legislation included in the Omnibus Reconciliation Act of 1987. The Congress explicitly clarified that facilities may charge residents for items and services requested and received that are not covered by the state Medicaid plan. We urge you to consider allowing Medicare beneficiaries to purchase additional services over and beyond what the Medicare program may legitimately reimburse.

THE UTILIZATION OF PRIVATE RESOURCES SHOULD BE MAXIMIZED

AHCA does not endorse the concept of first-dollar coverage of nursing home care with no deductible or copayment. This approach would result in the complete federalization of long term health care, which would drain the federal budget as well as eliminate the legitimate role that the private sector should play in the financing solution. First-dollar coverage would be prohibitively expensive and unnecessary, and would likely create a massive "woodworking" effect that would generate increased utilization -- a particular concern with long term care since the majority of care is provided by families and informal caregivers. Large segments of the population can -- and should -- provide for their own future needs. A two year deductible is a reasonable exclusionary period which will provide a needed incentive for individuals to purchase private long term care insurance. Private insurance offers these individuals a promising alternative to spending their assets and impoverishing themselves to pay for their long term care needs. The success of this approach, however, depends on the response of the private long term care insurance industry and its ability to design and market affordable insurance policies.

THE PURCHASE OF PRIVATE LONG TERM CARE INSURANCE SHOULD BE ENCOURAGED THROUGH CHANGES IN THE TAX CODE

A number of properly targeted proposals directed toward insurers, consumers, and employers could accelerate the development of long term care products. These include: allowing the deductibility of insurance reserves and related investment earnings; applying the same tax status to long term care products as now exists for health insurance premiums and benefits; offering a tax credit for the purchase of long term care insurance; allowing the inclusion of long term care benefits in "cafeteria" plans; and, eliminating the restrictions on the prefunding of retiree health benefits.

ENHANCE CONSUMER PROTECTION WITHIN THE PRIVATE INSURANCE MARKET

Many state legislatures have been active in ensuring quality long term care insurance products. Seventeen states are considering proposals to establish minimum standards for long term care insurance. Last year, ten states adopted versions of the National Association of Insurance Commissioners' (NAIC) model law, and another nine are expected to do so this year.

In response to research, consumer surveys, provider input and the NAIC recommendations, many insurers have modified their policies and are offering more flexible benefits along the long term care continuum. Restrictions, such as prior hospitalization requirements, are being removed in policies with time and additional market experience. We feel that it is important, however, for Congress to avoid the pitfalls of the early days of Medigap insurance development and to work now to protect the purchasers of private long term care insurance from abusive marketing practices.

We strongly support your bill, Mr. Chairman, S. 5085, the Long Term Care Insurance Standards Act of 1988, which would regulate private long term care insurance policies along the lines now used to regulate Medigap policies. Your bill would provide needed federal standards for long term care policies that would result in increased protection for our elderly against substandard and overpriced policies.

We look forward to working with you, Mr. Chairman, and members of the Subcommittee in the months ahead in your endeavors to improve our federal long term care policy.

Chairman STARK. Mr. Rodgers.

STATEMENT OF MICHAEL F. RODGERS, SENIOR VICE PRESIDENT, AMERICAN ASSOCIATION OF HOMES FOR THE AGING

Mr. RODGERS. On behalf of the American Association of Homes for the Aging, I appreciate the opportunity to present our views this afternoon on the issue of long-term care financing.

Our testimony basically addresses three issues: First, the need for a Federal long-term care program; secondly, the appropriate roles of the public and private sector in providing long-term care coverage; and finally, the needed dimensions of a long-term care system.

I think that the previous panels have already eloquently talked about the issues of the need for some type of long-term care policy, so I will dispense with that discussion in my testimony and move to issues of public and private sector involvement.

Clearly, considering the magnitude of the problems that we face today, some type of public/private partnership is going to be needed. It would seem to us that proposals to establish a full-blown national system of long-term care insurance are neither politically or economically feasible at this time, considering the growing national debt. States' capacities to fund chronic care services are equally precarious, with many states currently spending upward to 40 percent of total medicaid budgets for long-term care services.

With regard to a private sector involvement, the American Association of Homes for Aging believes that it will require a joint partnership between the individual, the employer and the private insurers.

Prefunding of benefits over the entire labor force certainly would make long-term care insurance affordable to the majority and ensure that no one individual would incur catastrophic expenses. Employers have a responsibility to help employees access insurance protection for chronic care services.

Additionally, I think private insurance carriers must also provide incentives for the purchase of protection by developing meaningful private insurance policies. We know through some of the previous discussions and some of the research that many of the existing policies are overpriced, offer little protection relative to cost, and fail to include coverage of services most preferred by consumers.

Several legislative proposals which have been introduced in this Congress would require individuals to be responsible for funding first-dollar coverage through private insurance. The success of this medicare stop-loss approach depends in part on the availability of private long-term care coverage and the individual's willingness to purchase such coverage.

In this regard, we believe Senator Mitchell's bill is a good first step with regard to looking at ways to encourage the promotion of the private insurance option through the utilization of certain tax incentives. Other Members of Congress have introduced similar legislation this session.

We support the clarification of the tax codes to make long-term care insurance a more attractive and sound opportunity for insurers, employers and individuals alike. Such expansion of incentives for private long-term care insurance should include meaningful consumer choices as well as protection measures.

Mr. Chairman, we are pleased to see that you have introduced legislation to establish standards for private long-term care insurance policies. We believe H.R. 5085 goes a long ways in providing that kind of protection to consumers and we support you in that effort.

Another option for integrating financing and delivery of long-term care services is the continuing care retirement community. I believe Dr. Wiener discussed that briefly this morning.

The continuing care retirement option has essentially been pioneered by the not-for-profit industry. We estimate that there are currently some 700 continuing care retirement communities throughout the country. Currently, our members are trying to explore ways to make this option more available to the low and moderately low-income individual.

In the area of public sector involvement, clearly we think the public sector needs to be involved in providing protection for those who are impoverished and making available assistance to low-income elderly to help defray some of the cost of long-term care coverage.

The public sector has the responsibility to encourage the development of mechanisms for financing and delivering care more efficiently. Case-managed health care systems represent one such cost-effective alternative.

We believe that a public long-term care program should be designed to provide coverage beyond a specific threshold, where an individual exhausts private insurance protection or where expenses become catastrophic.

Our last point involves the dimension of the long-term care program.

The first area we would like to cover is the area of eligibility.

Benefits should cover older people and consideration should be given to expanding eligibility for children or adults chronically ill or disabled. And benefits must involve a continuum of care.

Care should be available in the most appropriate setting. Benefits should be neutral relative to the site of care. They should not encourage institutionalization in order to obtain more adequate coverage.

As an aside point to the continuum question, we think that greater attention needs to be placed on the kind of coordination between the various Federal levels of Government, including the Congress.

We have been working with the Senate and House Banking Committees on reform of Federal housing programs which provides long-term care services.

The research from the Congregate Housing Services Program shows that there can be some distinct savings to the Medicaid program in the long run by delaying or preventing institutional care.

At the same time, we are concerned that necessary incentives in the housing area are provided. Thus, we were alarmed several weeks ago when the Ways and Means Committee approved an amendment to the tax technical correction bill, H.R. 4333, imposing conditions on the 501(c)(3) tax-exempt bonds.

We believe that this will make it difficult, if not impossible, for the not-for-profit sector to provide affordable housing that is linked to long-term-care services.

Mr. Chairman, we would urge the committee to take a look at that issue in greater detail.

Finally, in the area of financing, we are in favor of looking at the option of lifting the Social Security wage cap.

It would spread the financial risk of the long-term care over the broad base of the public. Furthermore, the public seems to support this option.

Social Security taxes could be augmented by other taxes, such as a surtax on gifts or inheritance. We suggest a sliding scale on taxes of all such income transfers with no exclusions.

Such a tax would expand the base in a progressive and equitable manner.

Finally, AAHA believes that beneficiaries should not be made to pay premiums other than those already enacted in the Catastrophic Protection Act at the present time.

In the future, it may be possible to reapportion premiums for both acute and chronic care benefits with some relation to beneficiary income.

Mr. Chairman, we appreciate the opportunity to address the committee today and will be glad to work along with you as you begin your arduous task of developing a meaningful long-term health care legislation.

[The statement of Mr. Rodgers follows:]

STATEMENT OF MICHAEL F. RODGERS, AMERICAN ASSOCIATION OF HOMES FOR THE AGING

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE, I AM MICHAEL RODGERS, SENIOR VICE PRESIDENT FOR POLICY AND PROGRAM IMPLEMENTATION OF THE AMERICAN ASSOCIATION OF HOMES FOR THE AGING (AAHA). AAHA IS A NATIONAL NONPROFIT ASSOCIATION REPRESENTING OVER 3,300 NONPROFIT FACILITIES PROVIDING HEALTH CARE, HOUSING, CONTINUING CARE RETIREMENT PROGRAMS, AND COMMUNITY SERVICES TO MORE THAN 500,000 OLDER INDIVIDUALS EVERY DAY. SEVENTY-FIVE PERCENT OF AAHA HOMES ARE AFFILIATED WITH RELIGIOUS ORGANIZATIONS WHILE THE REMAINING ARE SPONSORED BY PRIVATE FOUNDATIONS, FRATERNAL ORGANIZATIONS, GOVERNMENT AGENCIES, UNIONS, AND COMMUNITY GROUPS. WITH STRONG COMMUNITY INVOLVEMENT AND LONG-STANDING COMMUNITY TIES, AAHA MEMBERS ARE COMMITTED TO MEETING THE PHYSICAL, SOCIAL, EMOTIONAL AND SPIRITUAL NEEDS OF THEIR RESIDENTS IN A MANNER WHICH ENHANCES RESIDENTS' SENSE OF SELF-WORTH AND DIGNITY AND ALLOWS THEM TO FUNCTION AT THEIR HIGHEST LEVELS OF INDEPENDENCE.

MR. CHAIRMAN, I APPRECIATE THE OPPORTUNITY TO TESTIFY BEFORE THE SUBCOMMITTEE TODAY ON BEHALF OF OUR ASSOCIATION CONCERNING ISSUES RELATED TO THE DEVELOPMENT OF A MEANINGFUL LONG-TERM CARE PROGRAM. TODAY, I WOULD LIKE TO ADDRESS THREE KEY ISSUES REGARDING LONG-TERM CARE SERVICES: THE NEED FOR A FEDERAL LONG-TERM CARE POLICY, THE APPROPRIATE ROLES OF THE PUBLIC AND PRIVATE SECTORS IN COVERING LONG-TERM CARE, AND THE NEEDED DIMENSIONS OF AN APPROPRIATE LONG-TERM CARE SYSTEM.

NEED FOR A FEDERAL LONG-TERM CARE POLICY

CURRENTLY, THE UNITED STATES HAS NO FEDERAL POLICY FOR HANDLING THE LONG-TERM CARE NEEDS OF ITS ELDERLY AND DISABLED CITIZENS. UNFORTUNATELY, THE ELDERLY WHO REQUIRE CHRONIC CARE IN A NURSING HOME OR IN THEIR OWN HOMES MUST SPEND ALL THEIR FINANCES ON SUCH CARE, UNTIL THEY HAVE EXHAUSTED THEIR OWN RESOURCES AND "SPEND DOWN" TO MEDICAID ELIGIBILITY.

CLEARLY, THE NEED FOR LONG-TERM CARE IS GROWING. NEARLY 1.6 MILLION OF AMERICA'S ELDERLY ARE NOW LIVING IN NURSING HOMES, BUT THAT NUMBER WILL DOUBLE IN 30 YEARS. EQUAL NUMBERS OF ELDERLY CITIZENS ARE ESTIMATED TO BE IN NEED OF HOME AND COMMUNITY-BASED SERVICES IN THE FUTURE.

WHILE INCREASING GOOD HEALTH AMONG THE ELDERLY MEANS THAT MORE OLDER PEOPLE ARE ACTIVE AND ABLE TO TAKE CARE OF THEMSELVES, THE PREVALENCE OF DISABILITY INCREASES WITH AGE, AND THE FASTEST GROWING AGE GROUP IN OUR POPULATION IS THE GROUP 85 AND OVER. THUS THE CHALLENGE WE FACE IS TO PROVIDE THE KIND OF CHRONIC LONG-TERM CARE SERVICES NEEDED BY ELDERLY INDIVIDUALS WHOSE ABILITY TO PERFORM BASIC ACTIVITIES OF DAILY LIVING (SUCH AS EATING AND DRESSING) HAS BEEN IMPAIRED.

WE KNOW THAT THE ELDERLY WOULD PREFER TO REMAIN IN THEIR OWN HOMES AS LONG AS POSSIBLE, AND MANY ARE ABLE TO DO SO. EIGHTY PERCENT OF THIS NATION'S OVER-65 POPULATION REMAINS AT HOME, WITH OUTSIDE HELP IN SOME CASES. NEARLY 90 PERCENT OF THE DISABLED ELDERLY WHO REMAINED IN THEIR OWN HOMES RECEIVED ASSISTANCE FROM RELATIVES AND FRIENDS, SOMETIMES SUPPLEMENTED BY PAID PROVIDERS. AMERICAN FAMILIES EXPEND CONSIDERABLE TIME AND EFFORT IN TAKING CARE OF ELDERLY RELATIVES, WITH ONE STUDY ESTIMATING THAT FAMILIES PROVIDE MORE THAN 27 MILLION UNPAID DAYS OF INFORMAL CARE EACH WEEK. FAMILIES OFTEN INCUR SUBSTANTIAL PHYSICAL AND EMOTIONAL STRAIN IN CARING FOR THEIR ELDERLY RELATIVES, YET FEDERAL HEALTH POLICY DOES LITTLE TO SUPPORT THOSE FAMILIES. THE MODEST RESPITE CARE BENEFIT ENACTED AS PART OF THE CATASTROPHIC COVERAGE

ACT OF 1988 (P.L. 100-360) PROVIDES A FIRST STEP IN SUPPORTING FAMILY CAREGIVERS, BUT ITS REQUIREMENT OF THREE MONTHS OF UNRELIEVED FAMILY CARE PRIOR TO ELIGIBILITY IS A SEVERE CONSTRAINT ON THE BENEFIT. FAMILIES WITH NO RELIEF FROM THE BURDENS OF CAREGIVING MAY BE UNABLE TO MANAGE THREE MONTHS OF ASSISTANCE AND MAY BE FORCED TO PLACE THEIR RELATIVE IN A NURSING HOME. THIS IS PARTICULARLY TRUE WHERE THE CAREGIVER IS ALSO ELDERLY.

FOR THE ELDERLY WITHOUT FAMILY AND FRIENDS TO CARE FOR THEM, OR THOSE WHO NEED MORE SKILLED INTENSIVE CHRONIC CARE, THE MEDICARE HOME HEALTH BENEFIT OFFERS LITTLE ASSISTANCE. THE HOME HEALTH BENEFIT IS AN ACUTE CARE BENEFIT WHICH REQUIRES A PATIENT TO BE HOMEBOUND AND IN NEED OF PART-TIME OR INTERMITTENT SKILLED NURSING CARE OR PHYSICAL THERAPY FOR ILLNESSES WHICH WILL RESPOND FAVORABLY TO TREATMENT. ADDITIONALLY, IT DOES NOT COVER THE PERSONAL CARE NEEDED BY MANY OF THE ELDERLY, AND IT IS GENERALLY AVAILABLE FOR ONLY VERY SHORT PERIODS OF TIME.

THE MAJORITY OF SPENDING ON LONG-TERM CARE SERVICES IS FOR THE ELDERLY WHO CAN BE CARED FOR MOST EFFECTIVELY IN NURSING HOMES. HOWEVER, THE COST OF A LENGTHY STAY IN A NURSING HOME EXCEEDS THE FINANCIAL RESOURCES OF MOST OF THE ELDERLY. A REPORT LAST YEAR BY THE HOUSE SELECT COMMITTEE ON AGING REVEALED THAT SEVEN OUT OF TEN ELDERLY INDIVIDUALS LIVING ALONE SPEND DOWN THEIR INCOMES TO THE FEDERAL POVERTY LEVEL AFTER 13 WEEKS IN A NURSING HOME. WITHIN ONE YEAR, OVER 90 PERCENT OF SINGLE ELDERLY ARE IMPOVERISHED. NEARLY ONE-HALF OF ALL COUPLES ARE IMPOVERISHED AFTER ONE SPOUSE HAS SPENT A YEAR IN A NURSING HOME. THE RECENTLY-ENACTED CATASTROPHIC HEALTH BILL PRESENTS SOME MINOR RELIEF IN THE AREA OF SPOUSAL IMPOVERISHMENT, BUT MORE NEEDS TO BE DONE IN THIS AREA. BY SPENDING THEIR RESOURCES AND ASSETS TO PAY FOR CARE THESE ELDERLY BECOME ELIGIBLE FOR MEDICAID. APPROXIMATELY 50 PERCENT OF ALL NURSING HOME EXPENDITURES ARE PAID BY THE ELDERLY OUT-OF-POCKET. MEDICAID PAYS FOR 47 PERCENT OF THE REMAINING SERVICES, WITH MEDICARE PAYING FOR LESS THAN TWO PERCENT AND PRIVATE INSURANCE COVERING 1.4 PERCENT.

AS AMERICANS HAVE LEARNED OF THE LIMITATIONS OF MEDICARE COVERAGE FOR LONG-TERM CARE IN THE PAST FEW YEARS, THEY HAVE DECIDED THAT RELIANCE SOLELY ON PRIVATE ASSETS AND ON MEDICAID MAY NOT BE AN ADEQUATE SYSTEM FOR MEETING OUR NATIONAL LONG-TERM CARE NEEDS.

ROLES OF THE PUBLIC AND PRIVATE SECTORS

NATIONAL DELIBERATIONS OVER EXPANSION OF MEDICARE COVERAGE FOR CATASTROPHIC ILLNESS EXPENSES HAVE INTENSIFIED THE DEBATE OVER WHO SHOULD PAY FOR LONG-TERM CARE SERVICES. CONSIDERING THE MAGNITUDE OF EXPENDITURES REQUIRED TO FUND CHRONIC CARE SERVICES, FEW COULD DISAGREE WITH THE NEED TO FORM A STRONG PARTNERSHIP BETWEEN THE PUBLIC AND PRIVATE SECTORS IN IDENTIFYING SOLUTIONS. IT WOULD SEEM THAT PROPOSALS TO ESTABLISH A NATIONAL SYSTEM OF LONG-TERM CARE INSURANCE ARE NEITHER POLITICALLY NOR ECONOMICALLY FEASIBLE AT THIS TIME GIVEN THE GROWING NATIONAL DEBT. STATES' CAPACITY TO FUND CHRONIC CARE SERVICES ARE EQUALLY PRECARIOUS WITH MANY STATES CURRENTLY SPENDING UPWARDS OF 40 PERCENT OF TOTAL MEDICAID BUDGETS ON LONG-TERM CARE SERVICES.

SIMILARLY, WHILE LONG-TERM CARE INSURANCE WOULD BE AFFORDABLE TO MOST INDIVIDUALS OVER THE LONG RUN IF PRE-FUNDED ACROSS A SUFFICIENTLY LARGE RISK POOL, IN THE SHORT RUN, MANY OLDER PERSONS CURRENTLY REQUIRING CHRONIC CARE SERVICE, OR LIKELY TO NEED SUCH CARE IN THE NEAR FUTURE, DO NOT HAVE THE FINANCIAL CAPABILITY TO PURCHASE PRIVATE INSURANCE PROTECTION. THUS THE CRITICAL QUESTION REGARDING LONG-TERM CARE FINANCING MUST CENTER AROUND IDENTIFYING THE MOST APPROPRIATE AND FEASIBLE ROLES FOR BOTH THE PUBLIC AND PRIVATE SECTORS.

ROLE OF THE PRIVATE SECTOR

APPROPRIATE ROLES FOR THE PRIVATE SECTOR WILL REQUIRE THE JOINT EFFORTS OF INDIVIDUALS, EMPLOYERS, AND PRIVATE INSURERS.

TO ENSURE ADEQUATE FINANCING IN THE FUTURE, INDIVIDUALS SHOULD BEGIN PURCHASING LONG-TERM CARE COVERAGE DURING THEIR WORKING YEARS THROUGH EMPLOYER-SPONSORED HEALTH BENEFIT PROGRAMS. PRE-FUNDING OF BENEFITS OVER THE ENTIRE LABOR FORCE WOULD MAKE LONG-TERM CARE INSURANCE AFFORDABLE TO THE MAJORITY AND ENSURE THAT NO ONE INDIVIDUAL WOULD INCUR CATASTROPHIC EXPENSES.

EMPLOYERS HAVE A RESPONSIBILITY TO HELP EMPLOYEES OBTAIN ACCESS TO INSURANCE PROTECTION FOR CHRONIC CARE SERVICES. WHILE FEW WOULD DISPUTE THE POTENTIAL LIABILITY FACED BY MANY EMPLOYERS FOR UNFUNDED POST-RETIREMENT MEDICAL BENEFITS, EMPLOYERS CAN BEGIN OFFERING LONG-TERM CARE INSURANCE COVERAGE AS PART OF A MENU OF EMPLOYEE BENEFITS OR THROUGH EMPLOYEE-PAY-ALL PROGRAMS. THE AETNA AND TRAVELERS INSURANCE COMPANIES HAVE DEVELOPED SUCH POLICIES AND REPORT A 15 PERCENT PARTICIPATION RATE OF EMPLOYEES BETWEEN THE AGE OF 30 AND 50. THE FEDERAL GOVERNMENT SHOULD OFFER TAX INCENTIVES TO BOTH INDIVIDUALS AND EMPLOYERS TO ENCOURAGE WORKING-AGE ADULTS TO BEGIN PREFUNDING THEIR LONG-TERM CARE NEEDS.

WHILE PRIVATE INDIVIDUALS AND THEIR EMPLOYERS MUST TAKE RESPONSIBILITY FOR LONG-TERM CARE PROTECTION, PRIVATE INSURANCE CARRIERS MUST ALSO PROVIDE INCENTIVES FOR PURCHASING SUCH PROTECTION BY DEVELOPING MEANINGFUL PRIVATE INSURANCE POLICIES. MANY EXISTING POLICIES ARE OVERPRICED, OFFER LITTLE PROTECTION RELATIVE TO COST, AND FAIL TO INCLUDE COVERAGE OF SERVICES MOST PREFERRED BY CONSUMERS (I.E., CUSTODIAL, HOME AND COMMUNITY-BASED SERVICES).

AAHA SEES GREAT PROMISE IN USING A PUBLIC/PRIVATE PARTNERSHIP IN FUNDING LONG-TERM CHRONIC CARE SERVICES. SEVERAL LEGISLATIVE PROPOSALS WHICH HAVE BEEN INTRODUCED IN CONGRESS WOULD REQUIRE INDIVIDUALS TO BE RESPONSIBLE FOR FUNDING FIRST-DOLLAR COVERAGE THROUGH PRIVATE INSURANCE. MEDICARE COVERAGE WOULD BECOME AVAILABLE AFTER INDIVIDUALS SATISFY AN UP-FRONT DEDUCTIBLE.

THE SUCCESS OF THIS MEDICARE STOP-LOSS APPROACH DEPENDS, IN PART, ON THE AVAILABILITY OF PRIVATE LTC COVERAGE AND INDIVIDUALS' WILLINGNESS TO PURCHASE INSURANCE TO COVER SERVICE UTILIZATION DURING THE DEDUCTIBLE PERIOD. IN THIS REGARD, SENATOR MITCHELL'S BILL (S. 2305) WOULD AMEND THE FEDERAL TAX CODE TO ENCOURAGE THE PROMOTION OF THE PRIVATE INSURANCE MARKET. SUCH LEGISLATION WOULD:

(1) PROVIDE TO INDIVIDUALS TAX ADVANTAGES IN THE FORM OF TAX CREDITS FOR INSURANCE PREMIUMS AND TAX-FREE WITHDRAWALS OF INCOME FROM IRAS FOR PREMIUM PAYMENTS;

(2) PROVIDE EMPLOYERS WITH THE SAME TAX ADVANTAGES FOR CONTRIBUTING TO LTC BENEFIT PLANS AS THEY CURRENTLY ENJOY FOR CONTRIBUTING FOR ACCIDENT AND HEALTH INSURANCE;

(3) CREATE AN EXEMPTION FOR INTEREST EARNED ON LTC RESERVES BY INSURANCE CARRIERS.

OTHER MEMBERS OF CONGRESS HAVE INTRODUCED SIMILAR LEGISLATION TO PROVIDE TAX INCENTIVES WHICH ENCOURAGE EXPANSION OF PRIVATE INSURANCE OPTIONS.

AAHA SUPPORTS THESE REVISIONS OF THE TAX CODE TO MAKE LONG-TERM CARE INSURANCE A MORE ATTRACTIVE AND SOUND OPPORTUNITY FOR INSURERS.

THE SUBCOMMITTEE MAY ALSO WISH TO STUDY SEVERAL DEMONSTRATIONS WHICH ARE ALLOWING STATES TO DESIGN AND PURCHASE LONG-TERM CARE INSURANCE FOR MEDICAID BENEFICIARIES, SUCH AS THE NATIONAL SOCIAL HMO DEMONSTRATION AND DEMONSTRATIONS FUNDED BY THE ROBERT WOOD JOHNSON FOUNDATION IN SIX STATES, IN ORDER TO ASSESS POSSIBLE EXPANSION OF PRIVATE MARKET COVERAGE.

SUCH EXPANSIONS OF THE INCENTIVES FOR PRIVATE LONG-TERM CARE INSURANCE SHOULD INCLUDE MEANINGFUL CONSUMER PROTECTION MEASURES.

MR. CHAIRMAN, WE ARE PLEASED TO SEE THAT YOU HAVE INTRODUCED LEGISLATION TO ESTABLISH STANDARDS FOR PRIVATE LONG-TERM CARE INSURANCE POLICIES (H.R. 5805) ALONG THE LINES DEVELOPED TO REGULATE MEDI-GAP POLICIES. WE SUPPORT SUCH EFFORTS TO PREVENT ABUSES IN THIS BURGEONING INSURANCE MARKET. STANDARDS INCLUDED IN YOUR BILL, SUCH AS GUARANTEED RENEWABILITY AND PROHIBITION OF PRIOR INSTITUTIONALIZATION AS A CRITERION FOR SERVICE, WOULD DO MUCH TO RESOLVE PROBLEMS WITH CURRENT PRIVATE LONG-TERM CARE INSURANCE POLICIES. THE FUNDAMENTAL PROBLEM OF A LACK OF INDEXING FOR INFLATION WOULD REMAIN, HOWEVER, AND WE WOULD URGE YOUR SUBCOMMITTEE TO CONSIDER WHETHER CONGRESS SHOULD REQUIRE THAT BENEFITS REMAIN REASONABLE IN RELATION TO COSTS IN THE FUTURE, EITHER BY INDEXING FOR INFLATION OR BY PAYING A PERCENTAGE OF SERVICE COSTS.

ANOTHER OPTION FOR INTEGRATING FINANCING AND DELIVERY OF LONG-TERM CARE SERVICES IS THE CONTINUING CARE RETIREMENT COMMUNITY. THOSE COMMUNITIES OFFER LIFE CARE SERVICES, RANGING FROM INDEPENDENT LIVING ACCOMMODATIONS TO NURSING HOME CARE FOR THEIR RESIDENTS. RESIDENTS SIGN CONTRACTS FOR THIS EXTENSIVE PACKAGE OF HOUSING AND HEALTH SERVICES, AND PAY AN ENTRANCE FEE AND MONTHLY FEES. IN RETURN, THE COMMUNITY ASSUMES THE FINANCIAL RISK OF PROVIDING WHATEVER SERVICES THE RESIDENT NEEDS FOR THE REMAINDER OF HIS OR HER LIFE. THE CONTINUING CARE RETIREMENT OPTION HAS BEEN PIONEERED BY THE NOT-FOR-PROFIT SECTOR, AND WE ESTIMATE THERE ARE NOW APPROXIMATELY 700 SUCH COMMUNITIES THROUGHOUT THE COUNTRY.

MANY OF OUR MEMBERS ARE ALSO EXPLORING WAYS TO PROVIDE THIS OPTION TO LOW AND MODERATELY-LOW INCOME INDIVIDUALS. LIFE-CARE AT-HOME PROGRAMS REPRESENT ANOTHER INNOVATIVE PRE-PAID ALTERNATIVE OFFERING PROTECTION AT COSTS SUBSTANTIALLY BELOW LIFE-CARE FEES. NATURALLY, AN EFFECTIVE CARE MANAGEMENT SYSTEM NEEDS TO BE IN PLACE IN ORDER TO ENSURE QUALITY AND CONTROL COSTS.

ROLE OF THE PUBLIC SECTOR

APPROPRIATE RESPONSIBILITIES FOR THE PUBLIC SECTOR MAY INCLUDE PROVIDING INSURANCE PROTECTION FOR THE IMPOVERISHED AND ASSISTANCE TO LOW-INCOME ELDERLY TO DEFRAY THE COST OF COVERAGE. OTHER IMPORTANT ROLES OF THE PUBLIC SECTOR INCLUDE SUPPORT FOR THE DEVELOPMENT OF PRIVATE SECTOR INSURANCE IN THE DEVELOPMENT AND PROMOTION OF MORE COST-EFFECTIVE FINANCING AND DELIVERY SYSTEMS.

IMPLEMENTATION OF A MEANINGFUL LONG-TERM CARE PROGRAM MAY BE MANY YEARS IN THE MAKING, AND THE SYSTEM MAY NEED TO EVOLVE WITH SUCCESSIVE AGING COHORTS. SEVERAL APPROACHES MAY BE REQUIRED TO PROVIDE ADEQUATE AND EQUITABLE LONG-TERM CARE COVERAGE FOR DIFFERENT AGE POPULATIONS.

ONE APPROACH WOULD DEAL WITH THE ELDERLY WHO HAVE ASSUMED THAT MEDICARE WOULD COVER THEIR LONG-TERM CARE NEEDS AND HAVE MADE NO OTHER PLANS, AND WHO NOW FIND PRIVATE INSURANCE EXHORBITANTLY EXPENSIVE. ANOTHER APPROACH WOULD ADDRESS THE NEEDS OF THE NEAR-ELDERLY IN THE 50-65 AGE RANGE, WHO MAY NOT BE ABLE TO PURCHASE ADEQUATE INSURANCE TO FULLY PRE-FUND THEIR FUTURE LONG-TERM CARE NEEDS. A MORE MINIMAL APPROACH WOULD ADDRESS THE NEEDS OF THOSE NOW IN THE WORKING POPULATION WHO ARE ABLE TO PLAN AND PRE-FUND THEIR LONG-TERM CARE NEEDS.

THE PUBLIC SECTOR ALSO HAS A RESPONSIBILITY TO ENCOURAGE THE DEVELOPMENT OF MECHANISMS FOR FINANCING AND DELIVERING CARE MORE EFFICIENTLY. PRE-PAID, CASE-MANAGED CARE SYSTEMS REPRESENT ONE COST-EFFECTIVE ALTERNATIVE. THE NATIONAL SOCIAL HMO DEMONSTRATION MENTIONED EARLIER HAS ACHIEVED POSITIVE RESULTS IN OFFERING EXPANDED CHRONIC CARE BENEFITS TO OLDER BENEFICIARIES THROUGH A MODEL WHICH INTEGRATES ACUTE AND LONG-TERM CARE SERVICES. THE METROPOLITAN INSURANCE COMPANY HAS REPLICATED THIS MODEL IN AN HMO SETTING THROUGH A PRIVATE "WRAP-AROUND" POLICY.

COVERAGE FOR THE IMPOVERISHED AND LOW-INCOME ELDERLY COULD INCLUDE DIRECT PAYMENT FOR SERVICES AND/OR SUBSIDIZATION OF PRIVATE INSURANCE PREMIUMS. PUBLIC SUBSIDIES MAY REPRESENT AN EFFICIENT FORM OF ASSISTANCE SINCE THE PROVISION OF PRIVATE INSURANCE COULD REDUCE PRESSURES ON PUBLIC SECTOR PROGRAMS AND REDUCE FUTURE INCREASES IN PUBLIC SPENDING THROUGH THE ELIMINATION AND/OR REDUCTION OF THE MEDICAID SPEND-DOWN PROVISION. PUBLIC LONG-TERM CARE PROTECTION COULD BE DESIGNED TO PROVIDE COVERAGE BEYOND A SPECIFIED THRESHOLD, BECOMING EFFECTIVE AT THE POINT WHERE AN INDIVIDUAL EXHAUSTS PRIVATE INSURANCE PROTECTION OR WHERE EXPENSES BECOME CATASTROPHIC. FEDERAL SUBSIDIES OR COVERAGE MAY ALSO BE APPROPRIATE FOR THOSE WHO ARE UNABLE TO OBTAIN PRIVATE INSURANCE DUE TO HIGH UNDERWRITING RISK AS A RESULT OF ADVANCED AGE OR HEALTH RISK.

DIMENSIONS OF A LONG-TERM CARE PROGRAM

I WOULD LIKE TO TURN NOW TO ELEMENTS THAT AAHA BELIEVES SHOULD BE CONSIDERED IN ANY LONG-TERM CARE PROGRAM:

ELIGIBILITY

BENEFITS SHOULD COVER ALL ELDERLY INDIVIDUALS. CONSIDERATION SHOULD BE GIVEN TO EXPANDED ELIGIBILITY FOR BOTH CHILDREN AND ADULTS WHO ARE CHRONICALLY ILL OR DISABLED, WITH THE POSSIBILITY OF ELIGIBILITY PHASED IN OVER A NUMBER OF YEARS. TO BE ELIGIBLE FOR SERVICES, ELDERLY INDIVIDUALS WOULD HAVE TO BE IMPAIRED IN TWO OR MORE ACTIVITIES OF DAILY LIVING, OR SUFFER FROM DEMENTIA ACCOMPANIED BY BEHAVIOR PROBLEMS.

SERVICES

BENEFITS MUST INCLUDE A CONTINUUM OF CARE IN A VARIETY OF SETTINGS. CARE SHOULD BE AVAILABLE IN THE MOST APPROPRIATE SETTING, WHETHER THAT IS IN THE HOME, A NURSING HOME, AN ADULT DAY CARE CENTER OR OTHER APPROPRIATE FACILITY. BENEFITS SHOULD BE NEUTRAL RELATIVE TO THE SITE OF CARE, THAT IS, THEY SHOULD NOT ENCOURAGE INSTITUTIONALIZATION IN ORDER TO OBTAIN MORE ADEQUATE COVERAGE. SERVICES TO BE COVERED SHOULD INCLUDE, AT A MINIMUM, CUSTODIAL NURSING FACILITY CARE, HOME CARE, ADULT DAY CARE AND RESPITE CARE. PRIVATE INSURANCE POLICIES COULD PROVIDE COVERAGE FOR ADDITIONAL SERVICES (AS WELL AS FOR DEDUCTIBLE AND COINSURANCE AMOUNTS). BENEFITS SHOULD NOT BE CONDITIONAL ON PRIOR RECEIPT OF INSTITUTIONAL SERVICES.

MR CHAIRMAN, AS AN ASIDE POINT TO THE CONTINUUM-OF-CARE QUESTIONS, WE BELIEVE THAT GREATER ATTENTION NEEDS TO BE PLACED ON COORDINATION AT THE FEDERAL LEVEL, NOT ONLY WITHIN THE ADMINISTRATION, BUT ALSO WITHIN VARIOUS COMMITTEES OF THE CONGRESS. AS AN EXAMPLE, ONE OF THE KEY ISSUES THAT HAS SURFACED IN RECENT YEARS IS THE LINKAGE OF HOUSING AND SHELTER NEEDS OF THE ELDERLY WITH EXPANDED SERVICE AND HEALTH OPTIONS. BOTH THE SENATE AND HOUSE BANKING COMMITTEES PASSED LEGISLATION LAST YEAR THAT WOULD EXPAND THE CONGREGATE HOUSING SERVICES PROGRAM IN AN EFFORT TO DEAL WITH THE LONG-TERM CARE NEEDS OF THE ELDERLY IN SUBSIDIZED HOUSING.

ADDITIONALLY, AS WE HAVE NOTED PREVIOUSLY, INCENTIVES IN THE FORM OF TAX EXPENDITURES CAN HELP TO FACILITATE AN ACTIVE PARTNERSHIP BETWEEN THE PUBLIC AND THE NOT-FOR-PROFIT SECTOR. THUS, WE WERE CONCERNED WHEN SEVERAL WEEKS AGO, THE WAYS AND MEANS COMMITTEE APPROVED AN AMENDMENT TO H.R. 4333 (THE TAX TECHNICAL CORRECTION ACT) THAT WOULD IMPOSE SEVERE TARGETING RESTRICTIONS ON THE UTILIZATION OF 501(C)(3) TAX-EXEMPT BONDS. WE BELIEVE THAT THESE SEVERE TARGETING RESTRICTIONS WILL MAKE IT DIFFICULT IF NOT IMPOSSIBLE FOR THE NOT-FOR-PROFIT SECTOR TO PROVIDE AFFORDABLE HOUSING OPTIONS, LINKED TO LONG-TERM CARE SERVICES FOR THE ELDERLY. MR. CHAIRMAN, WE RESPECTFULLY URGE YOU TO EXAMINE THIS SITUATION IN GREATER DETAIL. THE IMPACT OF THIS AMENDMENT COULD HAVE SERIOUS CONSEQUENCES FOR THE FUTURE.

FINANCING

FINANCING FOR THE FEDERAL LONG-TERM CARE PROGRAM SHOULD COME FROM MIXED SOURCES OF FUNDING.

LIFTING THE SOCIAL SECURITY WAGE CAP HAS GREAT ATTRACTION BECAUSE THAT FINANCING MECHANISM WOULD SPREAD THE FINANCIAL RISK FOR LONG-TERM CARE OVER A BROAD BASE, THAT IS, THE WORKING POPULATION. SUCH AN APPROACH IS APPROPRIATE BECAUSE THE VERY NATURE OF THE NEED FOR LONG-TERM CARE SERVICES IN WHICH THE RISK FOR ONE INDIVIDUAL IS UNCERTAIN, LENDS ITSELF TO A SOLUTION BASED ON SHARED RISK. PUBLIC OPINION SURVEYS SHOW WIDESPREAD PUBLIC SUPPORT FOR USING THE SOCIAL SECURITY WAGE TAX TO FUND LONG-TERM CARE, EVEN BY THOSE INDIVIDUALS WHO WOULD BE PAYING THE HIGHER TAX. THOSE CONSIDERATIONS MUST BE WEIGHED AGAINST FUTURE PROJECTIONS FOR SOLVENCY OF THE MEDICARE TRUST FUND, HOWEVER.

SOCIAL SECURITY TAXES COULD BE AUGMENTED BY OTHER TAXES, SUCH AS THE SURTAX ON GIFTS OR INHERITANCE TRANSFERS. WE SUGGEST CONSIDERATION OF A SLIDING SCALE TAX ON ALL SUCH INCOME TRANSFERS, WITH NO EXCLUSIONS. SUCH A TAX WOULD EXPAND THE REVENUE BASE IN A PROGRESSIVE AND EQUITABLE MANNER. USE OF THIS TAX IS PARTICULARLY APPROPRIATE GIVEN THAT A MAJOR OBJECTIVE OF A LONG-TERM CARE PROGRAM IS ASSET PROTECTION.

AAHA BELIEVES THAT THE MEDICARE POPULATION SHOULD NOT BE OBLIGED TO PAY ADDITIONAL PREMIUMS BEYOND THOSE JUST ENACTED IN THE CATASTROPHIC PROTECTION ACT OF 1988 AT THIS TIME. ADDITIONAL PREMIUMS SHOULD REFLECT A BENEFICIARY'S FAIR SHARE OF PROGRAM EXPENSES, WITHOUT BEING A BURDEN TO THOSE ON FIXED INCOMES. IN THE FUTURE, IT MAY BE POSSIBLE TO REAPPORTION MEDICARE PREMIUMS TO ACCOMPLISH A MORE EQUITABLE DISTRIBUTION OF PREMIUMS FOR ACUTE AND CHRONIC CARE BENEFITS, WITH SOME RELATION TO BENEFICIARY INCOME.

MR. CHAIRMAN, I APPRECIATE THE OPPORTUNITY TO SHARE WITH YOU AAHA'S VIEWS ON FILLING THIS MAJOR GAP IN OUR HEALTH CARE SYSTEM. AS I NOTED EARLIER, IMPLEMENTATION OF A NATIONAL LONG-TERM CARE SYSTEM MAY BE MANY YEARS IN THE MAKING, BUT IT IS IMPORTANT THAT IT BEGIN NOW. AAHA LOOKS FORWARD TO WORKING WITH YOU AND YOUR SUBCOMMITTEE AS YOU DELIBERATE ON THIS AND OTHER MEASURES TO ASSURE ACCESS TO LONG-TERM CARE SERVICES FOR MEDICARE BENEFICIARIES.

Chairman **Stark**. I want to thank the panel.

Lest I am accused by those who agree and support me, I think we have to take some of the bitter with the sweet here.

All of you, I know, support this. The members of your associations would be providing most of the benefits and I am sure that you would join with us in extending those benefits to as many Americans as we can. It is something we can all agree to.

However, once we do this, how are we going to control the costs? I ask this because it is also your organizations who will be back here just as the American Hospital Association and the American Medical Association are now telling me that Medicare, which was designed in 1965, isn't paying them enough and they are all going broke. To preempt that a bit, I suspect that when we put this bill together, that would be the time to put the cost controls in.

So let me try a couple of ideas that you could comment on briefly.

The issue of quality care is difficult for all of us. Particularly for nursing homes, how do you write, how do you define in legislative language, tender loving care?

This is our area where we will need your assistance.

Universities have been studying this problem and I don't think there is a standard that can be agreed to.

Second, nonprofit institutions tend to act very much like profit institutions because they don't want to go out of business. However I suspect, while I am not sure that the industry agrees with me that overcapacity is creating some of our cost problems in the acute care hospital area. I wonder whether on a State level or a Federal level, if you all would agree that we ought to have some kind of—I hate to use the word—certificate of need. I know this conjurs up awful things to some people, but we need some kind of an allocation mechanism that prevents us from getting into the unfortunate situation that we are into, in my opinion, with acute care.

As I have said, this is an area in which I would hope that you would join with us. If we put these kinds of controls in at the beginning, and not just say that we are going to have cost reimbursement or something along those lines, then we will all be better off.

I would hope that we could inspire you to think about this because this will be the other side of what needs to be done if we are going to have a comprehensive policy.

It doesn't require an answer, but it is a charge that I would ask all of you to help us with because that is the bitter part of the sweet benefits for your members.

Mr. Gradison.

Mr. **Gradison**. Thank you.

My comments also don't require an answer, a comment or a response, but I just want to make an observation that the last time we sat here talking about a major expansion of benefits for the elderly of a new kind which was outpatient prescription drugs, the response of the provider industry was to go out and spend about $3.5 million of their own money to stop us from doing it. I think there were valid interests.

In their own self-interest, they were looking ahead. I didn't agree with their conclusion, but I could understand what they were doing.

Your response seems to be quite different.

Perhaps that is because you are already affected and in many cases adversely affected to the degree you depend upon Government payments today and maybe don't see a private sector solution coming along to bail you out anyway.

But I want to make that observation, it is a big difference and would be helpful in working this out to know that you want to play in the game with us.

We didn't have that exact feeling before with the other group.

Mr. **WILLGING**. Let's face it, the medicaid program is what drove the growth of the nursing industry. It is killing the industry today. And it is forcing the industry to choose between precarious financial survivability or poor quality care.

We are at the edge right now and we cannot continue to function nor can the residents we serve, continue to function where the quality of care is driven primarily by State, budgetary problems because it is going to do one of two things.

It is going to provide poor quality care or bankrupt the industry.

So given our dependence upon public financing, it is our intent to see a more reasonable approach to public financing.

Mr. **GRADISON**. In terms of fiscal soundness, you may be turning from one invalid to another, but that is your choice.

Chairman **STARK**. Just if I may intrude on Mr. Moody's time, do any of you have members or any relations with your counterparts in Canada?

I understand they provide long-term care at about 60 percent of the aggregate costs relative to the gross national product than we do. And I don't know anything about the system.

This probably isn't the time to go into it, but if any of you have any insight into what they do there that we don't do, or what they do differently, we would love to hear about it.

Mr. **RODGERS**. We do not have Members in Canada, but coincidentally next week, we will be meeting with the Ontario Association of Homes for the Aged, discussing this very issue in Toronto.

Chairman **STARK**. Mr. Moody.

Mr. **MOODY**. Thank you.

How many of you have members who are reimbursed under Medicaid?

I assume, Mr. Rodgers, you do?

Mr. **RODGERS**. A vast majority of our members receive some Medicaid reimbursement, yes.

Mr. **MOODY**. Do the other two of you have significant medicaid?

Mr. **WILLGING**. That is true of the entire nursing home industry.

Sixty-five percent are Medicaid patients, only 44 percent of the revenues are Medicaid. That is the basic discrepancy.

Mr. **MOODY**. There is tremendous disparity between States as to nursing home benefits, whether or not beneficiaries are eligible, who is eligible and so forth.

Mr. **WILLGING**. It varies State-by-State.

In some States, you—in some States you have to be below the poverty rate.

In the State of Arkansas, the rate for a day of skilled care is $30.75, largely dependent on the State's budget.

Unfortunately, most States back into the rate they will pay a nursing home.

This is the amount of money we can appropriate this year and this is what we need to have filled. We have the rate.

Mr. MOODY. A number of States don't allow nursing hospital as an eligible expense.

Isn't that true?

Mr. WILLGING. The nonskilled is mandatory.

Every State provides it, ICF benefit.

Mr. MOODY. OK.

Mr. RODGERS. The other thing is that some States also control the access to skilled nursing beds. So you have a State like Iowa, where there are virtually no skilled beds. They have a skilled nursing program, but the controls in the program itself are so strict that a very, very small percentage of patients are receiving skilled care.

The intermediate care has become the skilled care.

Mr. MOODY. It is on the books as an eligible expense, but in some States, it is almost impossible for people to get into it.

I mean, in Wisconsin, my State, there is a moratorium on any new nursing homes and beds under Medicaid.

So that benefits those who got in early and those who are coming on line now are just out of luck.

Is that typical?

Mr. WILLGING. It gets to the point, I think, that the chairman made about capacity.

The States have a clear propensity to keep the number of beds down because by definition for over 100 new beds they allow to be built, 65 of the patients will be Medicaid patients, 18 States have some form of formal or informal moratorium.

Mr. MOODY. So while the benefit is mandatory, it is only mandatory for an unspecified number of beds in terms of Federal mandates?

Mr. WILLGING. Yes, it is very difficult for a patient to achieve access to a Medicaid bed in some States.

Mr. MOODY. I gather all of you would agree that whatever we do in this committee, you do not want to see us model this on a Medicaid-type system.

Mr. WILLGING. Please, no.

Mr. HALAMANDARIS. The home care benefit under Medicaid is extremely limited and in some States it is almost nonexistent even though it is required to be provided.

Mr. MOODY. Is it a mandated benefit?

Mr. HALAMANDARIS. Yes.

Mr. MOODY. What is the constraint that States use to limit spending the way they use moratorium on beds to do so in an institutional setting?

Mr. HALAMANDARIS. It is a decision on their part not to come up with a matching contribution and use the money for home care.

They are so pressed to provide nursing home care that they don't use the dollars to provide home care service. And there is one State, New York, that receives 60 percent of all the Medicaid dollars that go into home care. One State receives that much.

Mr. WILLGING. One is to control the number of beds; second, they will control the rate such as in Arkansas at $30.

Mr. MOODY. If you can't break even at $30, the private provider won't do it.

Mr. HALAMANDARIS. You can't provide minimal care for $30. They will keep the number of eligibles down by having their financial level for eligibility very low and every State, almost every State has a preadmission screening program under Medicaid.

You cannot apply for acceptance in the nursing home until the State certifies the degree to which you need nursing home care.

Mr. MOODY. This is used as a screening device?

Mr. WILLGING. Yes.

Once a chronologically ill person is in a home, you may not go out, you have divested your resources and you have no place to go.

It is a one-way trip. So never model a long-term financing program after the Medicaid program.

Mr. MOODY. It would be interesting to hear about what are the pitfalls of Medicaid that we do not want to replicate in anything that we do in long-term care.

It has become a nightmare in my State. It is inequitable, expensive, and it is like a lottery as to who gets a bed and who doesn't.

It just has every possible feature you wouldn't want in a program for the elderly.

So that is why I ask you these questions.

If you want to drop me a note about the sort of things that we definitely don't want to do, I would appreciate it and that goes for home care as well.

Thank you, Mr. Chairman.

Mr. LEVIN. It has been a long day. We appreciate your setting this up. Lots of questions remain; they say that necessity is the mother of intention, I think there is necessity here, but we have to be very inventive.

So we will be bombarding you with lots of questions and I will withhold them, but don't be surprised if we individually send you lots of communications.

Thank you.

Chairman STARK. Thank you. I want to thank the panel. The information you have provided is very helpful. There will be a lot more discussion of this as we try to determine which route to take and how best to sell it to our constituents and to the public.

We appreciate your forbearance and continued assistance.

Thank you very much.

[Whereupon, at 2:25 p.m., the subcommittee adjourned.]

LONG-TERM CARE FOR MEDICARE ELDERLY AND DISABLED BENEFICIARIES

MONDAY, SEPTEMBER 26, 1988

House of Representatives,
Subcommittee on Health,
Committee on Ways and Means,
Washington, DC.

The subcommittee met, pursuant to call, at 2 p.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

Chairman **Stark**. The Subcommittee on Health of the Committee on Ways and Means will proceed. We are holding our third hearing on long-term care.

Meeting the needs of our elderly and disabled is a complex and difficult task that this subcommittee and the nation will face in the years ahead.

The growing numbers of old and frail Americans, the rapidly escalating nursing home and home health care costs and the inadequacy of our current patchwork system tells us that we cannot simply ignore the problem. We must look for a better way.

The stakes are very high. When fully implemented, a long-term care program will cost between $30 and $60 billion a year and affect the lives of millions of Americans. Financing these benefits will require substantially new and increased sources of revenue.

Today's hearing continues the Subcommittee's work on developing a sound approach to long-term care.

One of the major questions is how to determine who is eligible for long-term care benefits. Can we design a system that will both allocate services fairly and prevent gaming?

This is a key question because different utilization rates lead to widely different costs. The problems of uncertainties in this area were plainly evident during our discussions of the catastrophic drug benefit.

We must insure that the eligibility system prevents a long-term care program from becoming a bottomless pit.

Our first two witnesses this afternoon will address this central issue of eligibility.

Dr. Stanley Brody will explain how a system based on limitations in activities of daily living—ADL's—can determine who ought to receive long-term care benefits. Dr. Donna Cohen will discuss how we can insure that those with Alzheimers and other cognitive impairments can be screened to receive proper care.

Our second panel will provide information on how other nations meet the long-term care needs of their elderly while the third panel will discuss a number of innovative state programs that attempt to balance the roles of the public and private sectors.

Tomorrow I will introduce a Medicare long-term care bill. There will be a press conference on the new bill at 10:30 Tuesday in H-137 of the Capitol. This bill—together with those introduced by Senator Mitchell, Congressman Waxman and others—will serve as a base from which we can consider and hopefully build a firm foundation. The hearings we have held this year, should also set a firm foundation for the Subcommittee's consideration of long-term care legislation next year.

Mr. Gradison.

Mr. **Gradison**. Mr. Chairman, from the hearings that we have held so far it has seemed to me that the biggest problem that we had was trying to figure out how to raise the money for long-term care and once that was determined we probably could, in an afternoon, find a sensible way to organize and conduct the program.

I am confident that by the time this hearing is over it will be apparent to me, as I am sure it has been apparent to everybody else all along, that designing the benefits side is every bit as difficult as finding out how to fund the program.

I am looking forward to hearing the witnesses' testimony.

Thank you, Mr. Chairman.

Chairman **Stark**. Thank you.

Do any other Members wish to speak? If not I will call our first panel consisting of Dr. Stanley J. Brody, J.D., MSW, Director of Research and Training Center for Rehabilitation of Elderly Disabled Individuals, University of Pennsylvania Medical Center, Philadelphia, Pennsylvania; and Dr. Donna Cohen, Ph.D., Deputy Director of Gerontology Center, University of Illinois, Chicago, Illinois.

STATEMENT OF STANLEY J. BRODY, J.D., MSW, DIRECTOR, RESEARCH AND TRAINING CENTER FOR REHABILITATION OF ELDERLY DISABLED INDIVIDUALS, UNIVERSITY OF PENNSYLVANIA MEDICAL CENTER, PHILADELPHIA, PA

Chairman **Stark**. Dr. Brody, we have your prepared statement. Without objection, it will appear in the record in its entirety. You may proceed in any manner you are comfortable with. Welcome to the committee.

Mr. **Brody**. Thank you, very much.

My name is Stanley J. Brody. I am professor emeritus at the medical school and the Wharton School of the University of Pennsylvania. I serve as director of the Research and Training Center for Rehabilitation of Elderly Disabled Individuals, at the University of Pennsylvania.

One of the apparent results of successful income maintenance and accessible acute medical care has been the extension of life expectancy at 65 years of age. Because of high-tech medical intervention, the developmentally disabled, those who have suffered trauma, and those with chronic illnesses survive as disabled older people.

The health problems older people face today are those of disability resulting from chronic illness.

In the aggregate the aged are healthier than used to be the case. Their per capita use of health resources is steady or falling even though the median age of those over 65 is increasing.

The larger number of elderly accounts for the rise in the use of health care.

Thus the aging society presents a picture that contains a significant group of disabled older people, but whose aged cannot be described as "old, sick, and poor."

The disabled elderly are characterized by their inability to manage the tasks of daily living. These disabilities are in the Activities of Daily Living—ADL for short—bathing, dressing, getting to and from the bathroom or using the toilet, getting in or out of bed, getting around outside, eating and continence.

We now know the extent of ADL deficits of the elderly, both in the community and in nursing homes. If we define long-term care in terms of ADL deficits, we can define the risk. Long-term care then, Mr. Chairman, is not a bottomless pit.

If we use five ADL deficits or more, we know we are addressing the needs of 730,000 (1982) older persons living in the community and less than 600,000 who stay more than 90 days in nursing homes. A total of less that 1.5 million disabled elderly or less than 5 percent of the total aged population living in the community or in institutions is at risk of economic catastrophe for the long-term phase of continuity of care services.

This is significantly lower than the 9 percent of Medicare beneficiaries who use 70 percent of all Medicare expenditures.

If Congress wants to cover more of those disabled in nursing homes or the community by reducing ADL deficits covered to four or three, these risks can also be defined.

The second major point I want to make is that aging is a family affair. Families are the main providers of long-term care. Therefore the goal of long-term care services is to support multigenerational involvement in continuity of care by:

One, maximizing the functioning of the disabled elderly through rehabilitation oriented services—thereby improving their ADL levels and decreasing their need for assistance. Custodial care is an oxymoronic term. Thirty-five percent of those who live in the community with five to six ADL deficits improved their functional status between 1982 and 1984.

Two, providing long-term care services that support and strengthen families in their continuing and appropriate role of emotional service support. Institutional placement is appropriate when the older person or the family becomes endangered.

The need, then, is to recognize first, that health care of the elderly disabled is based on chronic illness rather than only on acute disease; second, that chronic illness requires intermittent or constant continuity of care that includes a wide spectrum of acute, transitional, and long-term services in institutions, in the community, and in the home; third, that the provision of continuity of care and particularly transitional and long-term care, is dependent on an active social support system; and fourth, that therefore, the goal of a system of health care for the disabled elderly is to provide for a full spectrum of continuity of care services.

To recapitulate, Medicare has provided well for acute care. The prospective payment system provides evidence that incentives have been effective in restricting the inappropriate use of acute care inpatient hospital beds. It has increased the need for and the utilization of step-down services such as home health care, short-term SNF and rehabilitation services. Thus the need for a rational health system that recognizes the interrelation of acute care with transitional care becomes apparent—an effect Dr. Kane has called ping-ponging. The movement of the disabled aged through the health care system is influenced by ADL and cognition deficits and the availability of social supports. Of course, the importance of the availability of third-party payors as regulators of this movement must always be kept in mind.

The current Medicare definition of three services—acute, transitional, and long term—is written in terms of acute disease rather than ADL terms of chronic illness. Long-term care, too, has been developed as a medical service and eligibility described in acute-care terms. Just as transitional services relate to acute care, so does long-term care. The population interchange among home health services, SNF's, acute-care hospitals, and other health services continuously reflects the needs of a chronically ill population who are characteristically disabled.

Provision of long-term services to meet the needs of this population is not a bottomless pit and must be provided in the context of continuity of care and of supporting the aging family.

Thank you for allowing me to meet with you on this real catastrophic issue.

[The statement of Stanley J. Brody follows:]

Testimony on

LONG-TERM CARE

by

STANLEY J. BRODY
University of Pennsylvania

Before The House Committee on Ways and Means
Subcommittee on Health
Washington, D.C.
September 26, 1988

My name is Stanley J. Brody, J.D., M.S.W. I am Professor Emeritus of Physical Medicine and Rehabilitation in Psychiatry, at the Medical School, and of Health Care Systems at the Wharton School of the University of Pennsylvania. I serve as Director of the Research and Training Center for Rehabilitation of Elderly Disabled Individuals, at the Hospital of the University of Pennsylvania.

One of the apparent results of successful income maintenance and accessible acute medical care has been the extension of life expectancy at 65 years of age. In the last 15 years, life expectancy at age 65 has increased about 15%, accounting for the whitening of a gray society. But, as Gruenberg has said, we are experiencing the "failures of success." Because of high-tech medical intervention, the developmentally disabled, those who have suffered trauma, and those with chronic illnesses survive as disabled older people. Just as the 1910 Flexner report on medical education presaged the development of scientific medicine by 30 years, so did the report of the 1957 Commission on Chronic Illness anticipate the beginning of the need for a societal response to disability by a similar time period.

While at any given time most of the elderly are free of significant disability, a large group nevertheless confronts adjustments associated with limitation in mobility and activities of daily living (ADL)*. Katz et al. have distinguished between life expectancy and active life expectancy, describing the last four-and-a-half years of life as characterized by disability for many aged; disability that is associated with death and not with age.

Fifteen years ago, a review of the estimates of the proportion of aged needing functional assistance suggested 30% as a reasonable mid-point between many estimates. Based on modified criteria, it was reported in the most recent National Health Interview Surveys (1984 and 1986) that six million, or 22.7%, of the elderly have at least one ADL deficit. About a million more or 27% had at least one instrumental activity of daily living (IADL)** deficits, a measurement which describes difficulty with home management activities. This confirms a series of secondary data indicating that, although society may be aging, in the aggregate the aged are healthier than used to be the case. Their **per capita** use of physicians, hospital care, and nursing home beds has been static or decreasing. Furthermore, poor health is no longer the major reason cited by most for leaving employment, and only 18% of those recent retirees reported serious limitations of activities. All of this presents a picture of an aging society which contains a significant group of disabled older people, but whose aged cannot be described in the aggregate as "old, sick, and poor".

The heterogeneity of older adults is now accepted as a given, leading us to differentiate among groups of aged. Just as a significant group of the elderly can be described as poor or needing acute care medicine, so, too, is there a group of disabled elderly needing assistance with the tasks of daily living. This group has been characterized as the long-term care population segment of the continuity of care spectrum of services.

*ADLs are bathing, dressing, getting to the bathroom or using the toilet, getting in or out of bed, getting around outside, eating, and continence.

**IADL includes heavy housework, light housework, laundry, preparing meals, shopping for groceries, getting around outside, going places outside of walking distance, managing money, making telephone calls, taking one's own medicine.

Defining the need for long-term care, is well underway. Parallel ventures between the fields of rehabilitation and gerontology have been undertaken for the last 2 decades. Contributors from both fields saw the need to measure function as the calibration necessary for determining health status of the chronically ill. Katz's original identification of ADL as the way to describe the level of function has been augmented by Lawton and E. Brody's IADL scale, the Barthel Index, and other assessment instruments. The wide use of these methodologies by health care providers has allowed for a description of the catastrophic need for long-term services as part of continuity of care to evolve.

The disabled elderly have now been measured in terms of the number and nature of ADL deficits. Although the **level** of the deficit provides a base line from which to measure change, the **number** of ADL deficits is emerging in study after study as the key to overall need for services as part of the continuity of care. Most old people in nursing facilities have from five to six ADL deficits; 849,000 older persons living in the community also have 5 to 6 ADL deficiencies. They were the ones who used one-third of all informal and paid assistance and spent more than half of the total out-of-pocket expenditures. Furthermore, hospital in-patients dependent in 5 to 6 ADLs were the ones most likely to exceed the average length of hospital stay for their Diagnosis-Related Group (DRG) classifications, and were predictors of death within a six month period and of nursing home admissions.

If the need for catastrophic long-term care is defined as having deficits in 5 and 6 ADL functions, then continuity of care is not a bottomless pit but one with clear dimensions. The **number** of the elderly in nursing homes was steady for the five years between 1977 and 1982 at one million residents as the result of more appropriate utilization. It has now risen to a population of 1.3 million because of the DRG forcing more appropriate use of acute in-patient hospital beds and creating the need for short-term step-down services.

Admissions from hospitals to nursing homes (SNF) rose to forty percent of all SNF entrants. Despite this increase, the 1975 Congressional projection of 3 million SNF beds by 1985 was considerably off the mark. A significant part of this recent rise in the SNF population can be attributed to the one-half of all SNF admissions who were admitted for less than a 90-day stay. Indeed, half of this 90-day stay group was for a period of less than one month. Of these short stay 631,000 admissions, about one-quarter died, almost half returned home and a large number went to the acute care hospital.

The remaining 600,000 who are long-term residents (average stay, 2½ years) have multiple disabilities. Thirty percent required assistance in all six ADL's. Half were dependent in more than five ADL deficiencies. The mean number of dependencies was 3.9. It is important to realize that, for this over 65 year age population, deteriorating cognitive functioning contributes more to dependency than physical impairments. In 1985, 63 percent of elderly residents were disoriented or memory impaired to such a degree that performance of the basic ADL's, mobility, and other tasks were deficient nearly every day. It should be noted that any advance in the control of senile dementia, particularly of the Alzheimer's type would have major repercussions on the number of those needing SNF placement.

In sum, then, a total of 1.5 million elderly disabled, or about 5% of the total population 65 years of age or over, living in the community or in institutions, have more than five ADL deficits. This 5% may be objectively designated as at-risk of economic catastrophe for the long-term care sector of continuity of care services. That figure is much lower than the 9% of Medicare beneficiaries who are at catastrophic risk for acute care and who use 70% of all Medicare expenditures. As each successive cohort of older people evidences an improved level of functioning, even in advanced old age, this is a manageable societal risk.

Should the requirement of five deficits be deemed too harsh, Congress has available adequate data to reduce eligibility for a long-term care program. Thus decreasing the number of ADL deficits by one to four or more would add 375,000 disabled living in the community and 175,500 living in SNFs for a total of two million elderly disabled or about 7% of the aged population. A decrease to three or more dependencies would add 500,000 disabled living in the community and 100,000 living in SNFs for a total of 2.6 million or about 9% of the aged populatin. As the number of ADL deficiencies drop, the rate of increase in the institutional population is much lower than the community population (viz., for two ADL deficits, 750,000 community dwellers and 125,000 institutional population would become eligible).

As the older adults have aged their needs can no longer be characterized as either for acute care or long-term care. Fifteen years ago the needs were described in terms of chronic care and requiring health/social services. Six years later it was pointed out that society's response to the health needs of the elderly was a medical care response with a ratio of 30 acute care dollars being spent to one dollar for health/social services. The goal for health care, as the 1978 Federal Long-term Care Committee chaired by Ethel Shanas stated, should be the maximum level of individual and family functioning. The credo of the masthead of the 1946 Journal of the Gerontological Society, "to add life to years, not just years to life," presaged that finding. This aphorism was first enunciated by George Morris Piersol, who established rehabilitation medicine at the University of Pennsylvania and whose name is inscribed on my place of work, the Piersol Rehabilitation Center.

For the last 10 years, we at Piersol, along with T. Franklin Williams, Director of the National Institute on Aging, have been advocating therapeutic optimism through rehabilitation for the disabled elderly. We have recognized that the goals of health care are changing from a focus only on curing to what Eisdorfer has called "long-term caring." Binstock added that long-term care can no longer be separated from rehabilitation. In that sense custodial care is an oxymoron term.

Continuity of care moves through three stages: first, acute care usually representing a hospital stay; second, transitional care, which is the brief time period, usually less than 90 days, subsequent to a hospital stay and allowing for transition to community living; and third, long-term care which may be intermittent, of varying intensity and locations, but continuous.

The movement of the disabled elderly through the health care system is continuous. Thus an elderly patient may see a succession of physicians or other health professionals, be admitted to an acute care hospital, and either return home or go to a variety of other health settings. These movements are now traceable. For example, the interchange of the elderly between hospital and nursing home: within the period of a year, of every 100,000 over 65 years of age, there are 37,000 admissions to a hospital from the community. Of these in-patients, 2,365 are discharged to a nursing home and in turn 1,510 are discharged from the nursing home to the hospital. This has been called the "ping pong" effect. The movement of the aged disabled through the health care system is influenced by ADL and cognition deficits and the availability of social supports.

Thus, the aged entering the health care system should be able to anticipate continuity of care rather than segmented acute care, transitional (sub-acute care), or long-term care. Whether we are confronting an Amyotrophic Lateral Sclerosis patient or an Alzheimer's patient, the remaining assets, whether mental or physical, must be actively maintained and conserved as well as maximized. There should be as much concern for the will to live as for the living will.

Repeatedly the need for continuity of care has been called a catastrophic need based on both the individual's and family's involvement in long-term care. Indeed, the family invented long-term care. Multiple research studies, both by the Federal Government and by independent researchers, have repeatedly concluded that families provide 80 to 90 percent of long-term care in the community. Gerontologists describe the catastrophic need for assistance and the catastrophic quality of the family experience in providing care. The individual need and the family need have been stated in broad terms, being focused on personal and family strain. Multigenerational involvement is integral to continuity of care.

There is general agreement that the societal response to the needs of the individual and the family for continuity of care has been inappropriate and inadequate. The policy response, whether in the private or public sector, has been consistent with previous reactions to human catastrophe. The concern is with economic, not social, cost. As currently defined, the catastrophic need for continuity of care has been perceived, almost universally, as a bottomless economic pit. Long-term care is seen as endless expensive nursing home and in-home care. The corollary to this perception is the view that the family will abdicate its responsibilities if formal services are provided. Researchers have disproven this last axiom, but the perception, however ill-founded, continues in some legislative corridors and administrative offices.

The need, then, is to recognize that the health care of the elderly disabled is based on chronic illness rather than only on acute disease. Secondly, that chronic illness requires intermittent or constant continuity of care which includes a wide spectrum of acute, transitional and long-term services both in institutions, in the community, and in the home. Thirdly, that the provision of continuity of care and particularly transitional and long-term care is dependent on an active social support system. And that therefore, the goal of a system of health care for the disabled elderly is to provide for a full spectrum of continuity of care services. The objectives of continuity of care is to maximize the functioning of the disabled elderly and the support and strengthening of families in their continuing and appropriate role in providing emotional and service support. The injection of "appropriate" recognizes the legitimacy of institutional placement when the older person or the family becomes endangered. Formal service availability should recognize the presence or absence of social supports.

Perception of catastrophe in economic terms is the sine qua non for policy change. Social response lags because of the lack of awareness by aging families. Mass denial is the barrier to the perception of continuity of care as an economic catastrophe that could confront all aging families. The concept of ageism is in fact age disabilityism. Just as society in general has traditionally rejected the disabled, that bias is continued into an aging society. The elderly themselves do not anticipate disability before death; disability is expectable but never expected. Because the event is not contemplated, the economic disaster that often accompanies it comes as a surprise.

To recapitulate, Medicare has provided well for acute care. The prospective payment program provides evidence that incentives have been effective in restricting the inappropriate use of acute care in-patient hospital beds. It has increased the need for and the utilization of home health care, short-term SNF and rehabilitation services. Thus the need for a rational health system that recognizes the interrelation of acute care with transitional care becomes apparent. The current Medicare definition of these three services is written in acute care terms of disease rather than ADL term of chronic illness.

Long-term care too, has been developed as a medical service and eligibility described in acute-care terms. Just as transitional services relate to acute care, so does long-term care. The population interchange among home health services, SNF, acute-care hospitals, and other health services is continuously reflecting the needs of a chronically ill population who are characteristically disabled. Provision of long-term services to meet the needs of this population must be in the context of continuity of care.

Chairman **Stark**. Thank you, Professor Brody.

Mr. Gradison, would you like to inquire from Professor Brody?

Mr. **Gradison**. Thank you, Mr. Chairman.

Dr. Brody, if you were in our shoes, how many ADL's would you require as a condition for qualification?

Mr. **Brody**. I would start at five, Congressman, and work down, but providing long-term care as a universal benefit. It really depends on the availability of funds, and you have made that point. What you have to establish, though, is the value. The value is to provide continuity of care and long-term care as part of that.

I think your first task is to make that first commitment. I think you made a wrong commitment on the catastrophic health care bill. This is the right commitment and it is time to get on with it.

Mr. **Gradison**. Would it make sense to have a sliding scale benefit where the more ADL's the larger the benefit? There are some bills that would do this. I have not really thought it through. I wonder what your reaction is.

Mr. **Brody**. I don't think that is really the issue. I think that the issue might be in terms of a sliding scale, in terms of income of the older person. I frankly have not thought of a sliding scale in terms of ADL either.

The reason I picked five ADL's is that the data show that the difference between four and five in terms of the families output of money and difference of effort between the two is very significant. So it becomes clear to me that when you reach that point, that is when you are into a catastrophe.

Mr. **Gradison**. One final question, Mr. Chairman.

This really gets down to a question of how much judgment is involved in measuring the ADL's. Is there any risk, to borrow a term we use in hospital reimbursement, is there any risk of ADL creep?

Mr. **Brody**. In the monopoly game that is played in this society, of course, there is. I think it is possible to define the terms in such a way that one can be reasonably sure of being able to check someone else's judgment.

The reason I put it in numbers rather than by degree was to avoid part of that problem. Once you get into the business of "is it a little bit or a lot?", then you get into issues like you are talking about.

But when you do the cumulative, then it becomes very difficult to mask the real situation.

Mr. **Gradison**. That is helpful. I recall the very decision we have been through in this committee, and the Social Security Subcommittee, relating to disability insurance and the determinations. I certainly came away from that experience with the feeling that if it is done that way, there is room for disagreement and you almost invite it.

I hope we can start down this road realizing there is always that risk but trying to minimize it, if we can.

Thank you, very much. I appreciate your testimony.

Chairman **Stark**. Mr. Levin.

Mr. **Levin**. No questions.

Chairman **Stark**. Mr. Pickle.

Mr. PICKLE. Mr. Chairman, I would like to defer my questions. I have not had a chance to read all of Mr. Brody's statement. So I thank you for the time being.

Chairman STARK. Mr. Coyne.

Mr. COYNE. Mr. Brody, I would be interested in hearing your thoughts on the role of expanded home health care. What functions would you include in home health care delivery? Do you see expanded services as a future alternative?

Mr. BRODY. Since the basic assumption is that we want to have the family continue to be involved, the way you can do that is to relieve the family of some of the things they do now. Our own experience is that when you provide services to the family, they don't walk away. There is plenty of research on that now. I don't think this is an arguable point. On respite care, one of the biggest problems has been getting families to use it, rather than to abuse it. So there are certain services that are not medically oriented but personal maintenance services, chore services, home health, et cetera, which can relieve the family of some of the burdens; the spouse for spouse, and the daughters and daughters-in-law of some of the burden of caring for their parent.

Those are the services where we need an expansion of the definitions. One of the reasons is that we keep on using medical definitions for problems which are inherently social problems, problems of living.

Mr. COYNE. If we were to go in that direction, should we be concerned about potential abuses that may accompany this expansion?

Mr. BRODY. I think yes, but I suspect it would not be from the users but rather the providers. Again, the chairman made a good point about how do we avoid gaming in this thing. In addition, how do you have the right people going into a person's home? Are these untrained strangers working for low pay?

We have to think carefully of how to protect the people we are trying to help and serve.

I think we have to have a licensing arrangement. We have to see to it that we have adequate pay for those kinds of services so that you can provide quality services. It makes no difference whether you are talking about an operating room or a homemaker. Quality service is the key.

Mr. LEVIN. Mr. Chairman, may I follow up?

Chairman STARK. Mr. Levin.

Mr. LEVIN. Should we pay family members to provide home care? We have discussed this.

Mr. BRODY. I don't know. In certain developed countries that actually happens. In Sweden they do pay families to care for older people. I don't think it is necessary. I think if you provided these other services that you relieve daughters and daughters-in-law enough so that they won't have to drop out of the work force in order to care for their parents. Twenty-five percent of the care givers do that.

Mr. LEVIN. You say to provide other services, supplementary services, so we begin to look at the practical details of a proposal. How do you set it up to make those decisions? You leave it entirely up to the family then?

Mr. Brody. No, I think you have to have some kind of an intervention. We have talked about case management as one way of doing it. Hopefully, physicians, if they see their role in this, might have a major participation, but they don't see it nor are they interested.

We have to see a mixture of social work and nursing in the case or service management intervention. This would be the regulator, to some extent the protector of the problems Mr. Coyne has raised and in terms of seeing to it that the right service is given at the right time.

Mr. Levin. In terms of the family involvement, if we don't provide compensation but provide supplementary services and some respite services, et cetera, it would be left up to the family if they participate otherwise or not.

We would not differentiate between family members in a community who were geographically available but did not participate and the same family type unit which did. There would be no differentiation in terms of our compensation or our response, except for some supplementary help for those families that became involved?

Mr. Brody. That is correct. I think there is a limitation of benevolence. There is just so much we can do in working with the family. Generally speaking, the track record of families is superb. There is pathology with children and pathology with parents, within families. You cannot look to a program like this to correct that kind of behavior.

We have enough experience now in giving these services to families that we see that families do not walk away. They continue their involvement. Their biggest problem is learning how to use these services to relieve themselves of some of the victimization of women that goes on in the case of parent care.

Mr. Levin. We began to discuss this when we looked at the Pepper bill. Are you in a position to describe briefly the state of case management capabilities in this country?

Mr. Brody. It is a good question. The development of case management services at this point is very minimal. We have tried to develop it in hospitals, using it for transitional care. There is no question that it is improving in quality and the level of case management is increasing.

The best way to insure good case management. as the Chairman points out, is to provide resources. Do that and we will have a plethora of case management services. The real problem is to define the case management services, to provide them properly, and then to continuously have a review process to be sure that they are not gaming the system.

Mr. Levin. You can abstain if you want on this one, but this is an urgent need and we need to think of it practically and pragmatically. How long do you think it would take to develop an effective case management network in this country?

Mr. Brody. There are some good models, the AAA agencies under the Older Americans Act, the older Americans program which you enacted in and the community mental health program in 1966. Both setting up a national system of catchment areas. So you have experience in having started programs like this. I think it would take from 3 to 5 years until you had a full blown system.

Mr. **Levin**. Thank you. Thank you, Mr. Chairman.

Chairman **Stark**. Mr. Pickle.

Mr. **Pickle**. Mr. Brody, I assume that your view of controlling long-term care is embodied in the establishment of some kind of system like the ADL's. You would have five or six, as you stated, and then you would have a certain number of people on it.

Mr. Stark stated in his statement to the committee today that long-term care is going to cost us something like 30 to 40 billion dollars a year. If we took the approach you suggested, if you had five or six ADL's, would the cost be in the range Mr. Stark indicated?

Mr. **Brody**. I don't think so. I think it would be significantly less. I think the approach ought to be the commitment to the program and then pricing out. That is why I approach it on the ADL.

If you want to approach it on a two-ADL basis, then I think the figures Mr. Stark raised are relevant. I think it has to do with the value you want to put on this kind of service.

Mr. **Pickle**. Most people who have introduced bills or advanced a particular approach apparently are using the ADL as their measurement to define who would be eligible and thus establish the cost.

I am trying to get it in my mind what the cost would be if the normal or best approach would be the five to six, as you suggest. You said it might be a little less than Mr. Stark indicated.

Mr. **Brody**. It would be.

Mr. **Pickle**. You don't recommend any one approach; you simply say this is the way to analyze the cost or eligibility or both.

Mr. **Brody**. I have not been elected, so I don't presume to tell you what to do. However, I have to tell you, you have already adopted a program that uses two ADL's. That is the respite program piece of the catastrophic bill which requires, if I remember correctly, two ADL's plus an irrelevant requirement—if you don't mind me saying so—of exceeding a physician's cost of $1,500 or $1,600.

But you already established, as part of this Congress, the rule of two ADL's on the provision of one of the services we are talking about, that is, respite care.

I might point out that the Vocational Rehabilitation Act has used the case management approach and the ADL approach over a long period of time. So there is experience out there.

Mr. **Pickle**. If we are at two ADL's now and we go to long term, as much as five or six, it will cost us in the neighborhood of $20 to $30 billion, so we might as well be prepared to face reality. That is that it is a very expensive program. I guess the level at which we set the ADL's is going to determine the eligibility and the cost.

Mr. **Brody**. That is correct.

Mr. **Pickle**. Thank you very much.

Chairman **Stark**. Dr. Brody, we have two out of five ADL's in the Medicare-catastrophic coverage bill. You have seven cut into different segments.

Is there a great professional concern about having five or six or seven ADL's? Is that something which reasonable professionals can work out and this committee does not have to get too involved with at this point?

Mr. **Brody**. That is correct.

Chairman Stark. I am wondering, moving back into the medical system and the way medical care is delivered to middle-aged Americans, if you have any feeling as to whether or not people who, if you will, grow up in an HMO or capitation-type environment, as opposed to people who grow up in a fee for service, primarily family physician environment, if there are any differences you or your group have observed as to which might lead us to a better health situation in the older years or better beneficiary approach to using medical and health care delivery services.

Do you have any feelings on this?

Mr. Brody. Not really.

I would make this one observation, which is a little off of what your question is. In the social health maintenance organizations, SHMO's, one of the major problems they have is getting older people to use the social service aspect of the program. In terms of the activity itself, I think the most important thing that can be done really in terms of health care for older people is their lifestyle. I don't know whether an HMO or PPO or any of those things really go to that kind of an issue.

Chairman Stark. One final question. I note here that on the last page of your testimony you indicate that the elderly do not anticipate disability before death. It is expectable but never expected, and because the event is not contemplated the economic disaster comes as a surprise. On the other hand, we are hearing some discussion today of a greater interest in private insurance.

I want to ask you to comment about this in its entirety. With private insurance policies, we have been reading recently that the conditions precedent to getting any benefits seem to be so stiff, for example, that you have to be in an accredited health care facility, you cannot go right from being sick to a nursing home—you have to pass "Go" to get your $200.

Do you have any comments on the kind of qualification standards the private insurance companies are using? Do you think they are too new for them to have any experience or do you think they are basically trying to exclude as many people as they can and are not really addressing the real issue?

Mr. Brody. There was a program tried by Metropolitan Life with the Puget Sound HMO that is worth looking at. None of the requirements that you talk about were involved. But the Puget Sound folks agreed to take responsibility for case management.

I don't know why it did not work out, because I heard it was well received by members of the HMO. That is the only place I know where there was a real constructive effort on the part of insurance companies to do some exploration on all the things that we have been talking about.

Generally speaking, the insurance companies are not in the insurance business, they are in the sure-thing business. It was the hospitals that first did things in insurance. It was Baylor Hospital in Texas in 1929. It was about 8 years later that the Blues got into it. The insurance companies didn't get involved in a major way until World War II, when cost-plus contracts gave them a sure thing. So I am not too hopeful about the insurance companies.

I am very cognizant of 40 percent initial markup of insurance companies. I see what happened with the medical policies. I must confess to a lack of optimism in that area.

Chairman **Stark**. I always find myself in the middle on jurisdictional disputes.

Is there any feeling now that there is any particular professional group—nurses, social workers, psychologists or any other particular profession or subprofession—that has a claim on this area of case management for seniors? Is it up for grabs? Does it make any difference?

I presume that gerontologists are the leaders, but would you care to comment on whether everyone who has a concern ought to be allowed to play or ought it to be limited by professional training?

Mr. **Brody**. I think that is a very good question.

In the experience that we had with the Robert Wood Johnson Program of hospitals providing case management, the two professions that emerged as dominant in this were nursing and social workers. It depended on the site and what I like to call the ecology of the place—that is, in some hospitals it was clearly the nurse who was in ascendancy; in Massachusetts, at Massachusetts General, it was the social workers; at St. Luke's in Boise, ID, it was the nurses who hired the social workers to work for them.

Basically I would say it is the social workers or nurses, and vice versa, who really have the role in this situation.

Chairman **Stark**. Thank you very much. I appreciate very much your sharing your advice and wisdom with us.

Unfortunately Dr. Cohen has had travel problems. It shows us the need for a Flier's Bill of Rights.

I would ask unanimous consent that Dr. Donna Cohen's statement appear in the record in its entirety.

I would like to thank you Dr. Brody for being with us today.

Mr. **Brody**. Thank you very much.

[Chairman Stark requested additional information from Mr. Brody. The following was subsequently received:]

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MEMORANDUM

TO: U.S. House of Representatives
Committee on Ways and Means

FROM: Stanley J. Brody, J.D., M.S.W.

DATE: October 7, 1988

SUBJECT: ADLs

Measurements are intrinsically involved in end results and, consequently, reflect values. Thus, the use of the Activities of Daily Living (ADL) measurement is not only geared to questions we ask, but also to the way we score and use the results.

It is suggested that the use of an ADL measurement as a method of establishing eligibility for long-term care benefits is intimately related to the purpose of the proposed program. These can be defined as (1) providing the appropriate assistance in a timely manner to the individual and his/her informal support system to maximize the functioning level of the individual so as to minimize the need for assistance and (2) providing the caregiving unit with a range of supportive services to enable them to continue the caring role in the home setting or using institutional placement appropriately. The purpose of the measurement, then, is to aid in evaluating the need for assistance.

The ADL measurement was originally formulated by Sidney Katz (1963) for charting the need for assistance by a geriatric disabled population. Attached (cf. Table 2-4) is the Katz index defining the tasks of bathing, dressing, going to the toilet, transferring, continence, and feeding. These scales have been used widely for 25 years with good results for reliability and utility.

Virtually every other measurement of function has used most of the same items as the core data for its particular approach [cf. OARS (Duke Univ., 1978); Functional Health Status of the Institutionalized Elderly (Mossey and Tisdale, 1979); Barthel Index (Mahoney and Barthel, 1965); PACE II (U.S. DHEW, 1978); and Brody and Lawton (1969) (cf. Table 2-3)].

In practice, the one addition to the Katz agenda is to cover mobility rather than continence. A goal of geriatric rehabilitation is independence, and, consequently, mobility is measured in terms of mobility within the house. On the other hand, the basic five items of the Katz and Congressional ADL listings, are deemed adequate in practice to establish need for assistance.

In the last four years, four major national samplings of the elderly have also used the Katz ADL items as a core for their data collection: (1) The 1982 Long Term Care Survey by the Bureau of the Census for DHHS designed to estimate the personal characteristics and use of health-related services by disabled, noninstitutionalized elderly; (2) the 1984 (NCHS, Advancedata, No. 133, June 10, 1987) and (3) the 1986 National Health Interview Survey (HIS), household-based surveys (more broadly-based than the 1982 LTC Survey) of functional limitations of elderly living in the community; and (4) the 1985 National Nursing Home Survey of use of nursing homes by the elderly, conducted by The National Center for Health Statistics (NCHS, Advancedata, No. 135, May 14, 1987). The LTC survey [cf. (1)] was a limited sample of only disabled elderly while the HIS (1982 and 1984) was a broader sample of all aged living in the community.

Katz	Catastrophic Act, Sec. 205(b)	LTC 1982 (1)	HIS 1982 (2)	Nursing Home Survey 1985 (4)
Bathing	Bathing	Bathing	Bathing	Bathing
Dressing	Dressing	Dressing	Dressing	Dressing
Going to the toilet	Toileting	Toileting	Using the toilet	Using the toilet
Feeding	Eating	Eating	Eating	Eating
Transfer	Transferring in and out of bed or in and out of a chair	Getting out of bed	Getting in and out of bed and chairs	Transferring from a bed or chair
Continence		Continence		Continence
		Getting around indoors	Walking	
			Getting outside	

It is clear from this table that the first five items of the Katz ADL formula have been repeated by Congress and the national data collections upon which it must depend for prediction of an at-risk population. While the data I used was based on LTC (1), nevertheless there is enough congruence with transfer to provide a solid base for five ADLs. The addition of other items in HIS and the Nursing Home Survey could be seen as not controlling.

Accordingly, I would recommend that the Committee go ahead with the five ADLs as noted in Sec. 205(b) of the Medicare Catastrophic Coverage Act of 1988 and consider using five ADL deficits as a very conservative approach, or four ADL deficits should they wish to further test the risk. As I suggested in testimony, the concern should not be with consumer abuse, but rather with, as Dr. Kane said, the spirit of entrepreneuerism among health providers and those who would be such.

SJB:lv

Attachments: from Kane and Kane, Assessing the Elderly. Lexington, MA: 1981.
(1) Katz Index of ADL (Table 2-4)
(2) Characteristics of Selected Measures of Ability to Perform Activities of Daily Living or Physical Functioning (Table 2-3)

Source: R.A. Kane and R.L. Kane
Assessing the Elderly: A Practical Guide to Measurement,
Lexington & Toronto: D.C. Heath
& Co. (Lexington Books), 1981.

Table 2-3
Characteristics of Selected Measures of Ability to Perform Activities of Daily Living or Physical Functioning

Name of Measure (Reference)	*Items Included*	*Type of Scale*	*Administration*	*Reliability*	*Validity*
PULSES (Moscowitz and McCann 1957, as referenced by Granger et al. 1975)	*P*hysical conditions; *U*pper limbs (self-care); *L*ower limb (mobility); *S*ensory components; *E*xcretory functions; *S*ocial problems.	Each item on 4-point Likert Scale from independent to dependent; score ranges from 6/6 for intact to 6/24 for complete dependence.			Correlates with Barthel and patient outcomes (Granger and Greer 1976).
Index of ADL (Katz et al. 1963)	Bathing; dressing; going to toilet; transfer; continence; feeding. Order of items reflects natural progression in loss and regaining of function.	Dichotomous rating of independence or dependence on each item; forms 6-level Guttman scale.	Professional raters using detailed anchoring statements.	Simultaneous observations; differences in less than 1 of 20 evaluations.	Correlated with mobility and house confinement after discharge.
Kenny Self-Care Evaluation (Schoening et al. 1965	17 activities in 6 categories: bed activities; transfers; locomotion; personal hygiene; dressing; feeding.	Each activity rated on 4-point scale: 0 = complete dependence, 4 = complete independence. An average score is created for each category, making total score = 24. Bottom and top points of scale precise with an expanded middle interval that patients pass through quickly.	Ratings by rehabilitation staff. Score constructed on basis of observations of how many of the substeps on each task the patient can perform.	Figures not quoted but subtasks and decision rules are precise so that reliability is encouraged.	Face and content validity; using scale, one can plot learning curves that predict total rehabilitation time and suggest when to discharge (Schoening and Iversen 1968).
Barthel Index (Mahoney and Barthel 1965)	Feeding; moving to bed; grooming; toileting; bathing; walking (propelling wheelchair); stair climbing; bladder control; bowel control.	Partial scores for performing with help, full score for independent performance; items weighted; full score of 100 signifies ability to do all tasks independently.	Rehabilitation-center staff perform ratings.		Scores and changes in scores correlate with clinical judgment; low scores predict mortality (Wylie 1967).
Rapid Disability Rating Scale (Linn 1967)	*16 items*: eating, diet, medication, speech, hearing, sight, walking, bathing, dressing, incontinence, shaving, safety supervision, confined to bed, mentally confused, uncooperative, depression.	Each item has value of 1, 2, or 3, with 3 indicating the greatest severity or occurrence. Scores range from 16 to 48.	Medically oriented raters (such as nurses) rate on first-hand information about patient. Instructed not to use record. Takes 2-3 minutes.	Inter-rater reliability and test-retest reliability are very high.	Scores correlated with physician's prognoses, number of previous hospitalization, length of stay, and 6-month mortality.
Barthel Self-Care Ratings (as adapted by Sherwood et al. 1977)	Drink from cup; feed from dish; dress upper body, dress lower body; don brace or prosthesis; groom self; wash or bathe; bladder continence; bowel continence; care of perineum/clothing at toilet; transfer chair; transfer toilet; transfer tub/shower; walk 50 yards; stairs; wheelchair; walk outside.	Each item on 4-point scale; Likert scale of intact, limited, helper, and null.	Ratings of staff; detailed descriptions for anchoring.	Sherwood et al. 1977 report alpha reliabilities of .95 for 3 separate samples of rehabilitation patients.	
Range of Motion (Granger 1974)	32 items dealing with specific motions of the shoulders, elbows, wrists, fingers, thumbs, hips, knees and ankles.	Each item classified as: performs against resistance; performs not against resistance; passive motion only; combination of active and passive motion.	Patient demonstrates and staff rates.		
PACE II: Physical Function (U.S. DHEW 1978a)	ADL section includes: goes outside; walking; climbing stairs; transferring; wheeling; bathes/showers; toileting; dressing; grooming; eating; range of motion on 17 items including left and right digits, wrist, elbow, shoulder, ankle, knee, and hip, head and trunk; 8 items on strength, balance and coordination (such as grasping, rolling).	ADL items classified as: mechanical aid; human help; does not perform. Rehabilitation potential for each item also classified. No overall score derived. Range of motion requires checklist for motion subject cannot perform; strength, balance and coordination items have yes/no subparts.	Rated by nurse examiner; ADLs rated on basis of usual performance in last 2 weeks; other items rated by asking patient to perform task.		
OARS: Physical ADL (Duke University 1973)	Eating; dressing; grooming; walking; getting in and out of bed; bathing/showering; getting to bathroom on time; continence.	Each item rated on 3-point scale for ability to perform independently; a global ADL/IADL score (range: 1-6 assigned, or from excellent to completely impaired.	Interview with respondent.	See chapter 5	
Functional Health Status of the Institutionalized Elderly (ADL-A) (Mossey and Tisdale 1979)	Getting out of bed; eating; drinking; walking; bathing; dressing; toilet use.	Each of 7 items on 4-point scale, from 0 = never needs help to 3 = always needs help; analysis of total scores + ability to eat and drink independently produced 9 categories that more specifically reveal patterns of dependency.	Investigators constructed index from secondary data from the Survey of Institutionalized Persons. Nursing-home personnel completed original instrument for sample.	Cannot assess inter-rater reliability. Coefficient of reproducibility = .958; high internal consistency of items; coefficient alpha = .94.	Correlates with independent criteria from same study—for example, bed confinement, ability to walk, blindness, and items suggesting admission for social reasons.

Source: R.A. Kane and R.L. Kane
Assessing the Elderly: A Practical Guide to Measurement,
Lexington & Toronto: D.C. Heath
& Co. (Lexington Books), 1981.

Table 2-4
Katz Index of ADL

Index of Independence in Activities of Daily Living

The Index of Independence in Activities of Daily Living is based on an evaluation of the functional independence or dependence of patients in bathing, dressing, going to the toilet, transferring, continence, and feeding. Specific definitions of functional independence and dependence appear below the index.

A	Independent in feeding, continence, transferring, going to toilet, dressing, and bathing.
B	Independent in all but one of these functions.
C	Independent in all but bathing and one additional function.
D	Independent in all but bathing, dressing, and one additional function.
E	Independent in all but bathing, dressing, going to toilet, and one additional function.
F	Independent in all but bathing, dressing, going to toilet, transferring, and one additional function.
G	Dependent in all six functions.
Other	Dependent in at least two functions, but not classifiable as C, D, E, or F.

Independence means without supervision, direction, or active personal assistance, except as specifically noted below. This is based on actual status and not on ability. A patient who refuses to perform a function is considered as not performing the function, even though he is deemed able.

BATHING (Sponge, shower or Tub)
Independent: assistance only in bathing a single part (as back or disabled extremity) or bathes self completely
Dependent: assistance in bathing more than one part of body; assistance in getting in or out of tub or does not bathe self

DRESSING
Independent: gets clothes from closets and drawers; puts on clothes, outer garments, braces; manages fasteners; act of tying shoes is excluded
Dependent: does not dress self or remains partly undressed

GOING TO TOILET
Independent: gets to toilet; gets on and off toilet; arranges clothes, cleans organs of excretion; (may manage own bedpan used at night only and may or may not be using mechanical supports)
Dependent: uses bedpan or commode or receives assistance in getting to and using toilet

TRANSFER
Independent: moves in and out of bed independently and moves in and out of chair independently (may or may not be using mechanical supports)
Dependent: assistance in moving in or out of bed and/or chair; does not perform one or more transfers

CONTINENCE
Independent: urination and defecation entirely self-controlled
Dependent: partial or total incontinence in urination or defecation partial or total control by enemas, catheters, or regulated use of urinals and/or bedpans

FEEDING
Independent: gets food from plate or its equivalent into mouth; (precutting of meat and preparation of food, as buttering bread, are excluded from evaluation).
Dependent: assistance in act of feeding (see above); does not eat at all or parenteral feeding.

Source: S.Katz, A.B. Ford, R.W. Moskowitz, B.A. Jackson, and M.W. Jaffee, "Studies of Illness in the Aged. The Index of ADL: A Standardized Measure of Biological and Psychosocial Function," *Journal of the American Medical Association* 185 (1963):94 ff.

Table 2-4 (continued)

Evaluation Form

Name ________________ Date of Evaluation __________

For each area of functioning listed below, check description that applies. (The word *assistance* means supervision, direction of personal assistance.)

BATHING—either sponge bath, tub bath, or shower

☐	☐	☐
Receives no assistance (gets in and out of tub by self if tub is usual means of bathing)	Receives assistance in bathing only one part of body (such as back or a leg)	Receives assistance in bathing more than one part of body (or not bathed)

DRESSING—gets clothes from closets and drawers—including underclothes, outer garments and using fasteners (including braces, if worn)

☐	☐	☐
Gets clothes and gets completely dressed without assistance	Gets clothes and gets dressed without assistance except for assistance in tying shoes	Receives assistance in getting clothes or in getting dressed, or stays partly or completely undressed

TOILETING—going to the "toilet room" for bowel and urine elimination; cleaning self after elimination and arranging clothes

☐	☐	☐
Goes to "toilet room," cleans self, and arranges clothes without assistance (may use object for support such as cane, walker, or wheelchair and may manage night bedpan or commode, emptying same in morning)	Receives assistance in going to "toilet room" or in cleansing self or in arranging clothes after elimination or in use of night bedpan or commode	Doesn't go to room termed "toilet" for the elimination process

TRANSFER—

☐	☐	☐
Moves in and out of bed as well as in and out of chair without assistance (may be using object for support such as cane or walker)	Moves in or out of bed or chair with assistance	Doesn't get out of bed.

CONTINENCE—

☐	☐	☐
Controls urination and bowel movement completely by self	Has occasional "accidents"	Supervision helps keep urine or bowel control; catheter is used or is incontinent

FEEDING—

☐	☐	☐
Feeds self without assistance	Feeds self except for getting assistance in cutting meat or buttering bread	Receives assistance in feeding or is fed partly or completely by using tubes or intravenous fluids

Chairman **Stark**. Our next panel will consist of Dr. T. Franklin Williams, Director of the National Institute on Aging of the National Institutes of Health; Dr. Robert Kane, dean of the School of Public Health of the University of Minnesota; and Dr. Sandra Newman, associate director for research, Institute for Policy Study of Johns Hopkins University.

I want to welcome the panel and repeat that your testimony will appear in the record in its entirety. I encourage you to add to it, summarize it or present it in any manner you are comfortable with. We will hear from all three of you before the Members inquire. I am calling on you in the order you appear on the witness list.

Dr. Williams, you may begin.

STATEMENT OF T. FRANKLIN WILLIAMS, M.D., DIRECTOR, NATIONAL INSTITUTE ON AGING, NATIONAL INSTITUTES OF HEALTH

Dr. **Williams**. I am T. Franklin Williams, Director of the National Institute on Aging of the National Institutes of Health.

I am very glad to have the opportunity to describe some features of long-term care for older persons in northern Europe. My wife, a medical social worker, and I have had the opportunity to visit many of these facilities first-hand, and have read descriptive writings about them by others. I have made copies of a recent compendium on "Quality of Long-Term Care" in the Danish Medical Bulletin available, courtesy of the Kellogg Organization which supported the publication. These articles are the product of an international work group which met in The Netherlands in 1986. My wife and I visited selected nursing homes in Sweden, Denmark and The Netherlands in 1987. I have also had the opportunity earlier to visit one of the most innovative homes, namely, Ten Kerselaere Geriatrics Center in Belgium.

Our visitations and the published accounts, including similar findings in Scotland, opened our eyes to a level of excellence in nursing home care which is not often seen in nursing homes in the United States, but which is certainly within our capabilities.

Perhaps the best way to summarize the nature of care in these countries is in the term "truly individualized care," an approach which was made national policy in Sweden, for example, a few years ago. Fundamentally this means that each person, on admission to a nursing home and while a resident in the nursing home, is approached and related to with the same respect to her or his own individuality, integrity and wishes as would be true in that person's own home or anywhere else in society.

For example, a resident in those nursing homes chooses when to get up in the morning, when and where to have breakfast—that is, in her or his own room or in a common room—what to wear, and what her or his day's activities will be. Residents and their families are also encouraged to bring in furnishings not only for the resident's room but also for the common rooms. Much effort is spent by the staff in working with residents to find the most comfortable chair for each individual. Most of these features of individualized care are in contrast to the typical approach in this country, copied from the institutional model of an acute care hospital, and which requires a nursing home patient to fit into institutional routines and furnishings.

The most striking difference in these homes I am describing is that there is virtually no use of restraints, either physical or medical. There are no "Geri-chairs," no Posey restraints, no bedside rails. Staff members in these nursing homes work, again individually, much as a family caregiver would do at home, to meet the needs of each resident without tying her or him down or otherwise limiting ordinary freedom.

The standard bed can be lowered to within one and a half feet of the floor so that people with short legs can reach the floor, and, should a restless or unsteady resident roll out of bed, she or he simply rolls onto the floor. The beds can be raised to simplify personal nursing care.

Specific staff members are assigned on a continuing basis to each resident, as opposed to the frequent rotation of assignments common in the United States. This promotes better understanding of the idiosyncrasies of each person. If a resident shows some agitation, tendency to wander or belligerent behavior, a staff member who knows that resident will spend some extra time in whatever ways have been found to relieve the agitation of that particular person. It could be sitting and talking with the person, holding their hands, inviting the person to join the nurse as she makes her rounds, encouraging a period of walking around an enclosed outside garden, or providing some favorite snack.

Similar restraint-free care is reported from Scotland, and in at least one report from Canada a nursing home moved from considerable use of restraints to almost restraint-free care without any increase in serious injuries or problems. This is in contrast to the prevalent use of restraints in nursing homes in the United States. For example, a recent ombudsman report from New York State indicates that 60 percent of the residents of nursing homes in that State are restrained at least some portion of every day, a percentage which may also be reflective of elsewhere.

This individualized care in northern Europe is accomplished with essentially the same range of disabilities in residents as here, including dementia, and with little, if any, higher staffing ratios. In northern Europe there is less turnover in staff and more sustained and continuous in-service training. The difference in morale and enthusiasm for work which individualized care has produced is epitomized by the comment of a director of nursing, formerly a staff nurse, in a nursing home in Gothenberg, Sweden, who said, in effect, "Before we moved to individualized care, I used to hate to come to work because I could hear patients screaming from down the street. Now it's a pleasure to come to work."

One home we visited in Skaevinge near Copenhagen, Denmark, has taken what would seem to be the ultimate step in individualizing care in what was a nursing home but is now treated explicitly as one more residential setting of the community. The nursing and support staff of that nursing home have been incorporated into the visiting nurse and home care services of the entire community. Residents of what was the nursing home are now considered to reside there in exactly the same sense as if they were living in any other house or setting in the community. Each person and her/his family works out with the staff the nature and extent of services just as they would in their own home. The room of each resident is now her/his own domain, with a doorbell and a personal lock and mail slot. The experience with this approach in the first one to two years has been very successful.

There are isolated examples of approaches to truly individualized care in nursing homes and continuing care retirement communities in this country, including restraint-free care, but they are exceedingly rare. The point in describing these approaches, which are more generally in use in the Northern European countries, is to call attention to what is possible. I am sure we all want to learn from excellence and to integrate it both in policy and practice.

Fortunately there is growing interest in such individualized and restraint-free approaches in this country. Both my wife and I have been called upon to speak to numerous groups, made up of both professional and lay persons, on this subject. The question almost always raised reflected concerns about the risk of a lawsuit should a nursing home resident fall and injure herself or himself because no restraints were used. To the best of my knowledge, there has yet to be a successful suit against a nursing home in this country because of a fall with injury because restraints were not used. In fact, there are a number of reports from the Food and Drug Administration and Consumer Products Safety Commission of serious injury and death to unfortunate residents who were asphyxiated, strangled or severely burned as they struggled against restraints.

Our methods of paying for nursing home care and home care services differ from those of these European countries, but I doubt that this fact is of much significance in accounting for the striking differences in quality of care. In most of those countries a person on entering a nursing home pays a proportion, but not all, of her or his lifetime monthly pension; the remainder of the costs are paid through federal, state and local taxes. There is considerable local autonomy in supervision of nursing homes, within the broad framework of national policy as well as society's level of expectation.

We could certainly benefit from learning more about nursing home and home care in these and other countries. We need to know more details about their staffing, training, payment, and care for residents with special needs, such as older mentally disabled persons, that is; the lifelong disabled. In addition, we should learn more about outcomes in terms of rehabilitation after discharges to home and the minimization of acute hospitalization. In my judgment, the most important step for us in the United States, for both the professional and lay public, is to make a commitment to and move toward achieving truly individualized and virtually restraint-free care. I believe this is well within our reach.

I will be pleased to answer any questions which the committee may have.

Thank you.

Chairman **Stark**. Thank you.

Dr. Kane.

Dr. **Kane**. Thank you.

STATEMENT OF ROBERT L. KANE, M.D., DEAN, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF MINNESOTA

Dr. KANE. I am Robert Kane, dean of the University of Minnesota School of Public Health and a researcher on issues related to long-term care and aging. I would like to report on the results of work done by my wife, Rosalie, and myself studying several Canadian provinces as models of what might be accomplished in the United States.

I think it is important to understand some of the background of the Canadian system. It is a series of provincial programs bound by adherence to a set of basic principles reenforced by federal funds. The differences in provincial programs are even greater in the area of long-term care, which is not a mandatory service and which has consequently emerged in some rather different forms in the several provinces.

The basic Canadian long-term care model builds on a framework of universal coverage for health services, a situation which applies in this country only to Medicare, but to no other part of our population.

Long-term care is an optional service, which provinces can provide with some of the block grant funds they receive from the Federal Government. Not all provinces have instituted long-term care programs—as of 1985, the four economically disadvantaged Maritime provinces had not enacted a universal nursing home benefit but hoped to do so as soon as feasible—and certainly those that have do not look the same. Most have extended the concept of universal coverage to include long-term care, but a few have tied long-term care into more of a welfare driven system, in which the government becomes the payor of last resort after the person has used up his own resources.

Canada, as a whole, began its long-term care programs with a heavy investment in institutional care. Philosophically, as well as geographically between the United Kingdom and the United States, Canada has had a higher nursing home and hospital bed per population ratio than the United States. Expansion into home care was seen by some as a way of reducing institutional care, but the effects must be sought over a long period in view of the heavy commitment to institutions already there.

The Canadian federal guidelines recognize five levels of institutional care: one, residential; two, extended care; three, chronic hospital; four, rehabilitation; and, five, acute medical. The latter three are automatically covered by the universal health insurance program. Extended care is the basic form of nursing home care, but some provinces operate institutional beds that cover residential care as well. In others this is handled in homes for the aged, which may be the responsibility of a more socially oriented ministry. In still other cases the latter care may be covered by more than one ministry.

The Canadian long-term care economy is mixed. Although there are probably stronger inclinations toward nonprofit and public sponsorship for long-term care services in Canada than in the United States, both proprietary and nonprofit agencies exist. One does not find as strong an entrepreneurial climate in Canada as in the United States. Large chains and proprietary franchises have not fared as well there.

Functional disability, rather than age or particular diagnosis, determines access to long-term care programs. In Ontario physicians certify the need for long-term care, but in most provinces, need is established by case managers or care coordinators who function independently of the delivery of medical care. Anybody can refer himself or a family member or a client for an assessment of long-term care need, and based on that assessment the need for care at a particular level of intensity will be certified. Different provinces have established different levels for institutional care—for example, four levels in Manitoba and five in British Columbia—and each successively higher level corresponds to a greater number of maximum hours that can be authorized for home care.

Typically the decision about the level of need is made independently of the decision about where that care should be given. The latter decision is largely up to the patient and the family, with a few caveats: the province will not ordinarily pay a higher price for care at home than care for the same patient would cost in a nursing home and, although patients are helped to enter the nursing home of their choice, they may be asked to temporarily accept a less preferred choice rather than remain in a hospital at the expense of the health insurance program.

Provinces have developed remarkably similar ways of charging for nursing home care. Each resident pays a fixed daily amount for the standard accommodation that is meant to equal a rent for the housing component of the service. The consumer copayment is indexed to rise in the cost of living and is intended to be affordable on publicly financed pensions. Facilities may charge patients for some additional services or amenities, for example, dry cleaning or private-duty nursing. Facilities are prohibited from levying charges for personal care and housekeeping. Because residents retain their own incomes and assets, some can afford single rooms, extra amenities and other consumer goods.

The provincial contribution to the nursing home rate in for-profit facilities is negotiated annually between the Ministry of Health and the provincial nursing home association. Although this is a lively bargaining process, it seems less stark an adversarial relationship than persists between the industry and State governments in the United States. Nonprofit facilities, typically owned by sectarian or civic groups, are usually reimbursed differently. Their residents pay the identical daily rate as would a resident in a for-profit facility, but the provincial government underwrites the operating costs of the facility through a prospective budget that is meant to pay for its operating deficit.

Home care providers tend to be paid per visit or per hour for personal care and homemaking. Rates are generally negotiated between the provincial health department and the agencies. In some provinces, homemaking is construed as a social service, rather than a health service, and those rates are therefore developed in each county by negotiation between the agency and the county department of social services. In either case the rates established may be agency-specific.

By way of general background, Canada is a slightly younger country than the United States. Only 10.6 percent of its population is aged 65 or older, compared to over 11 percent in the United States. Its population is much smaller, the equivalent of the State of California, but its land mass is greater than that of the United States.

Canada has enjoyed relative success in controlling its health care costs. A 1988 report by R.G. Evans suggests that the difference in the proportion of GNP spent on health in Canada and the United States is the same as the potential savings in administrative costs from moving to a universal entitlement program. Canadian per capita health expenditures have been increasing during the last decade.

In general, the pattern of expenditures across the provinces reflects the development of long-term care services; the more total dollars spent, the greater the long-term care investment. One partial exception to this rule is Quebec, where deliberate policies have been established to transfer support from acute to long-term care.

National data on long-term care in Canada is difficult to find. Because each province has its own system and is independently funded, little aggregate data is available. Certain census data has been used to estimate that 7.3 percent of the Canadian population aged 65 and over are in an institution. Utilization data from 1981 indicates 0.8 percent of the elderly received meals on wheels, 3.5 percent transportation services, 4.3 percent homemaker or home help services, 4.3 percent assistance with shopping and banking, and 2.7 percent nursing or other medical calls at home. Every province has at least some home care program that provides both nursing and homemaker services; most have no income restrictions or user fees.

Each of the three provinces we examined reflects a different history with regard to long-term care. Ontario began its long-term care program first, in 1972, but targeted it primarily toward nursing home care. Only recently has it begun to focus serious attention on community care. Manitoba represents the model for community-based care. Its continuing care program, which began in 1974, has served as the prototype for several other provinces including British Columbia, which added a long-term care benefit in 1978.

In the last several years there has been an impressive convergence in the three provinces as they have moved toward balanced programs that provide both community-based and institutional care. The early expectations that community care would displace institutional care have been displaced by an appreciation that both components are needed and that both can be provided within affordable budgets. This is not to suggest that the cost of health care is not a matter of concern in any of the provinces; to the contrary, it is a regular topic of debate. What distinguishes these discussions from those in other places is that long-term care is an intrinsic part of the health care system and hence its benefits are weighed alongside those of other components, rather than held to different examination from without.

The bed ratio per 1,000 elderly persons in the United States is about midway between the range for the three provinces, although the American variation among states is much greater. The 1982 public expenditures per nursing home bed were about the same in the two countries, but the total costs per bed were higher in the United States than in any of the three provinces. There is great variation in the proportion of nursing home beds in proprietary facilities. Ontario comes closest to the United States' pattern of proprietary predominance.

In 1972 Ontario introduced its extended care benefit, which covers "standard ward care," that is, four beds to a room, in a nursing home. Residents pay a fixed daily amount keyed to minimal government pensions. In 1984 the user charge of about $16 per day left residents who were entirely dependent on government income maintenance programs with $96 per month for personal expenditures, an amount at least three times larger than that allowed by the most generous state medicaid programs. Additional charges for semi-private and private accommodations, when not medically required, and other amenities are strictly controlled and generally affordable. A physician's evaluation determines eligibility, but it is then up to the client to find a nursing home.

The extended care benefit is used in two distinct types of facilities: nursing homes and homes for the aged. Nursing homes, which are 95 percent proprietary, are paid at a flat per diem rate negotiated annually between the Ontario Nursing Home Association and the provincial government. In 1984 that standard rate was about $43 per day, with the government paying the $27 that remained after the user contribution. At that time the province had 332 nursing homes and about 29,000 beds for its population of 8 million. When the government needs more beds in a geographic area, it undertakes a competitive bidding process. The right to provide more beds is awarded not on the basis of price—because the per diem is fixed—but on the relative quality promised in the proposals.

Homes for the aged, which predate the extended care benefit, began under the auspices of social welfare programs. They were established by municipalities or nonprofit organizations to provide residential care to senior citizens who could not or preferred not to live in the community. Residents pay according to their means, and the deficits of the homes are met by the sponsoring organization or municipality and the province. When the extended care benefit was introduced, qualified residents of homes for the aged were able to use the benefit without relocating to a nursing home. There are now approximately 13,000 persons in extended care beds in homes for the aged, as compared with 14,000 in residential beds. Such clients pay the customary user charge, but the home is reimbursed for actual expenses because the government picks up the deficit. Under that system, not surprisingly, extended care costs more per capita in homes for the aged than in nursing homes.

Ontario also has a category of hospitals offering long-term care—chronic hospitals—which in 1982 had about 11,500 beds. Those beds are paid for as part of the hospital's global budget from the province. Chronic care hospitals may be free-standing but are usually sections of general hospitals. As part of the hospital insurance system, the chronic care hospital is free to the user. However, after the 60th day all residents in such hospitals—and, indeed, all residents in acute care hospitals waiting for a lower level of care—are assessed a $16 daily residential charge.

Since 1968 Ontario has had a medically oriented acute home care program as part of its health insurance benefit. It includes nursing and therapeutic services and a maximum of 8 hours of homemaking per admission. A pilot program of "chronic home care" was introduced in 1975. It permitted 80 hours of homemaking in the first month and 40 hours in each subsequent month per admission, assuming that at least three visits a month were required for professional care. By 1984 such care was available in each of the 38 health districts, and the province was considering a homemaking service benefit for persons not requiring professional home care.

Home care is free. Its amount is determined by home care case managers located in each health district. The Ministry of Health purchases nursing services from voluntary agencies at rates negotiated at the provincial level. The Ministry of Health purchases homemaking services either from nonprofit agencies—the Red Cross is a major vendor—or from proprietary agencies at rates negotiated by social service authorities in each county. Although home care case managers have a sharply limited role, they represent a major source for rationalizing home-based services. The admissions process for institutional services is more unruly. In some districts, agencies called "placement coordination services" have been established by voluntary agreement among the hospitals and long-term care facilities in the region. The place coordinator completes an assessment of all extended care applicants and manages a centralized waiting list.

Manitoba is a vast province with only about 1 million people, half of whom are in Winnipeg. Its long-term care program differs from Ontario's in several respects. The physician's role in determining eligibility is much smaller, home care services are better developed and the system has more controls. Only about a quarter of Manitoba's nursing homes, called personal care homes, are proprietary.

Manitoba recognizes four levels of nursing home care, from level 1, at which residents are assumed to require no more than 30 minutes of daily nursing attention, most of which can be given by nursing assistants, to levels 3 and 4, at which residents are assumed to need at least 3.5 hours of nursing care per day, 20 percent of which requires a registered nurse. Level 4 is analogous to the care provided by Ontario's chronic care hospitals and is usually offered in extended care units of general hospitals. Manitoba has a higher ratio of nursing home beds per elderly population than the other provinces studied, largely because of an accrued excess of minimal care level 1 beds clustered in facilities that are not suitable for more severely impaired clients. As in Ontario, the resident pays a fixed per diem price-keyed to the pension system. In 1984 it was $13. Proprietary homes are paid on a daily rate, negotiated with the government, for each level of care, and nonprofit homes are paid according to global budgets negotiated prospectively.

Since 1974 community care and case management have been provided by continuing care programs housed in each local health and services department. Nurse-social worker teams serve as continuing care coordinators who assess eligibility for all long-term care services, including nursing home care, home care and day care. Homemaking is provided directly by public employees, up to the maximal number of hours authorized by the coördinators. Nursing and other therapeutic services are usually provided directly, too, but, especially in Winnipeg, may be purchased from nonprofit agencies. All home care is free, with no copayments.

No person may enter a nursing home without the case being reviewed by an interdisciplinary panel. The home care coordinators are responsible for assessing applicants for nursing homes, organizing the information for the panel hearing and managing the waiting list of persons who have been accepted for facilities. The panel reviews medical information from the applicant's own physician and social information, providing a fail-safe measure against admitting a person to a facility for a functional impairment instead of trying to remedy the problem. Because home care coordinators also manage admission to facilities, there is a link between the two benefit programs and the possibility for tradeoffs in their use. Home care expenditures per client are usually limited to those for nursing homes at the same level. Exceptions are made for short-term terminal care or if no nursing home bed is available. Applicants are encouraged to make their own first and second choices of facilities. If forced to enter a different facility to free up a hospital bed, they are put on the waiting list for the facility of their choice.

British Columbia's program is modeled on Manitoba's approach. Both insured institutional care and insured homemaker care were introduced in January 1978 after a well-advertised public information campaign. This provided a sharp test of the new system's ability to meet the initial demand.

All adult residents of British Columbia are eligible for insured nursing home care, subject to small user charges, as in Ontario and Manitoba. Five levels of care are recognized: personal care, three levels of intermediate care, and extended care. The last, generally given in extended care units of hospitals, is for persons who are unable to get out of bed by themselves. Intermediate Care III is largely reserved for psychogeriatric care. During our study period, nonprofit facilities were paid according to negotiated global budgets and proprietary facilities were paid fixed per diem rates. In 1984 the province introduced per diem rates for all facilities.

The province, which has a population of about 2.8 million, is divided into 22 districts for the administration of the long-term care benefit. In each district, case managers, who are usually nurses but may be social workers or physical therapists, assess the functional status of any applicants and determine their level of care. Case managers may authorize homemaker services up to maximal limits set for each level of care. For example, a person considered to be in need of personal care only is entitled to up to 40 hours of homemaking per month, whereas a person who needs extended care is entitled to up to 120 hours of homemaking per month. Exceptions to these limits are allowed in emergencies, as respite for family caregivers or for persons awaiting space in a facility. The case manager may also authorize day care. If the applicant prefers a facility, the case manager puts him or her on the waiting list, and home care may be provided in the interim. Homemaker services are purchased from for-profit and nonprofit agencies. Home nursing is provided directly by nurses employed in the public health departments in which the case managers are also housed.

Case managers in British Columbia are expected to review each case every 6 months, after every intervening hospitalization, or as requested by the client or the care provider. Case managers continue to follow up their assessments of levels of care and their planning after a client enters a facility—a contrast with Manitoba's system. However, British Columbia has not introduced a paneling system like that in Manitoba.

The Canadian experience represents tangible evidence that long-term care can be incorporated into an affordable universal health insurance program for which functional dependency, rather than poverty, is the primary criterion for eligibility. Part of the answer may lie in the centralization of funding, which effectively pools resources from health and social sources.

Long-term care in Canada has generally been operated as a social program but funded through health dollars. This approach has provided access to potentially large resources and has allowed at least some modest cross-subsidization. Critics of this approach fear that it will eventually lead to a dominance of a medical model with an undue emphasis on cure rather than support and rehabilitation. The Canadian experience offers basis for more optimism. Despite the financial sponsorship as a health service, the programmatic efforts have been generally able to support appropriate long-term care activities. In each of the provinces studied, there was a real shift in health expenditures. Growth in the hospital sector was slowed to support long-term care. As we grapple with the imminent constraints on total health care resources, the potential for cost-shifting within a single health care budget seems an increasingly important option to maintain.

As noted earlier, the Canadian long-term care market is a mixed one. Both proprietary and nonprofit agencies provide services. The ratio of profit to non-profit varies from province to province. In some cases there is a deliberate effort to maintain the mixed market, under a belief that there are advantages to both approaches and special advantages to fostering some modest level of competition. Both types of providers can be effectively utilized if there is effective oversight and opportunity for control.

The Canadian system demonstrates the importance of a monopsony, whereby a single organization controls the funding. Under such a system there is real potential for rational control whereby the payor can send clear market signals about the kind of care it wants to see provided. As long as a reasonable price is offered, the supply of care can be well matched to the need for it and the form can be shaped to meet beliefs about what is most efficacious.

The Canadian approach represents a floor model. In contrast to a welfare approach, each recipient is provided at least a minimum package of services according to need. Personal resources can then be used to augment this floor of benefits to purchase amenities above this minimal package.

The elderly in both Canada and the United States have been viewed as a special group. They are seen as both venerable and vulnerable. More recently, however, especially in the United States, the elderly are portrayed as affluent, often having profited more from social programs than other groups, especially children. In truth, aging is associated with great variation. The older the group in question, the greater the variance, whether we talk about health or wealth. Interestingly, the Americans and Canadians have continued to support care for older people, even while there may be concerns about using public money to improve their income indiscriminately. Poll after poll in the United States shows solid support for public coverage of long-term care. In Canada there continues to be strong support for such programs.

One question this raises in the United States is the issue of the older person's right to leave an inheritance. There is great concern that public dollars not be used to protect the assets of older persons who do not have a living spouse or other dependent.

In Ontario this problem has been addressed to some degree in the approach to payment for homes for the aged. The estates of older persons are charged, after the person's death, for the care provided. This charge has prior claim over inheritance. Although such an approach may become unwieldy, it offers a way to avoid means testing and still not subsidize those who do not need such subsidies.

On the other hand, many in Canada argue that long-term care, like health care, is a right and should not preclude an older person from leaving an inheritance. Those who saved for years should not have to use their resources when those who failed to save do not. As pressures for funding LTC grow, this area may become the most vulnerable.

It is also important to note that the frequently heard fear that a liberal program of formal long-term care sources threatens to displace the informal bedrock of long-term care is simply unsubstantiated. Carefully done studies provide ample evidence that the level of informal care persists in the face of organized care. Formal care supplements rather than supplants informal care.

One area where the Canadians have experienced many of the same problems seen in other countries is the linkage between acute and long-term care. Within the Canadian system this confusion is further exacerbated by the operation in many provinces of extended care beds provided by the hospitals. Because the Canadian hospitals tend to be paid under a system of global budgeting, there is a tendency to keep patients longer than might absolutely be required.

The hospital's role in long-term care is important but difficult to define. The hospital is often the point of entry for long-term care. Most persons begin their long-term care careers from a hospital discharge. Because long-term care is chronic, it does not mean that the person stops needing acute care. Quite to the contrary, long-term care recipients are about twice as likely as those not dependent to need future acute care. It is thus difficult to define precisely where one form of care begins and another ends.

Unfortunately the interfaces between these modalities are often not smooth. Much of the care is provided by different personnel, although a primary care physician is, at least in theory, a common link. In practice there is redundancy of information collected and a lack of coordination in the services provided. Jurisdictional boundaries reduce efficiency.

The separation across modalities of care applies to the data available, as well. Even where sophisticated data systems have been created in the acute and chronic disease sectors, they exist as separate entities with little opportunity to cross-walk between them to look for overall patterns of use and changes in status.

Nor has Canada done especially well in linking housing and long-term care. Although there are examples where the different programs have worked cooperatively to address client needs, there is no overall policy. Indeed, much of the confusion around the Ontario Homes for the Aged stems from jurisdictional differences about what kinds of care can be given where, under what auspices. There is little evidence of creative new packages of services that separate the housing and nursing care components into more flexible bundles, individualized to clients. But there is nothing precluding such reconfigurations.

The Canadian system is not strong on quality assurance. The Canadians have apparently not seen a pressing need to develop quality assessment approaches beyond general oversight. Regulation seems to be a much friendlier matter than in the United States, with the governmental officials viewed largely as allies of the providers working to improve what is usually believed to be good care. The closest to an American regulatory approach is seen in Ontario, the province most like the United States There, one can sense some concern about the variation in care standards and growing pressures to improve quality. There is an innate belief that the quality in proprietary homes is less than in the nonprofits, but, as in the United States, there is little hard data to substantiate that claim.

A principle emerges from Canada to reinforce observations made in other parts of the world: The organization of long-term care requires local control. Even in the relatively small provinces of Canada, smaller geographical units were utilized for regular oversight and program accountability. In the United States there is some enthusiasm for market competition. The Canadian approach demonstrates the advantages of geopolitical responsibility, where everyone in an area is covered by a single program and that program is then responsible for the care provided and hence for omissions in care as well. Market competition, with its attendant search for market niches, too often leaves market gaps.

The nature of long-term care is changing rapidly. The distinctions between home care and institutional care are rapidly disappearing. Newer forms of care, which combine housing and nursing care, are beginning to emerge. These new forms of care will require equally new and differently funded consortia. Housing has up to now been quite separate from health. With the new configurations of care, this distinction will become less clear. Flexible approaches to caring for dependent populations will mean crossing jurisdictional boundaries and pooling funds from several sources.

As the modalities are further mixed, the issues of who should pay for what will be re-examined. At present, food and housing are costs generally expected to be met from individual income, including welfare subsidies. The Canadian separation of a nursing home copayment, roughly equivalent to a room and board charge, although generally a substantial underestimate of that cost, is based on that philosophy. As services are further uncoupled, this distinction will become more obvious and the issues of coverage as a health and social program benefit will need to be re-examined.

Questions of cost effectiveness will require examining a number of areas of expenditure, with careful attention to total costs and full episodes of care. The nature of long-term care invites an investment philosophy, whereby extra effort may be placed in one sector with the expectation of recovering the costs of that effort by avoiding complications later.

As Dr. Brody has indicated, one of the most important and germane points as we look at the long-term care in this country, based on the Canadian example, is informal care in a system that is well funded and well administered, continues at the same rate it did before that program was introduced.

As we have looked at research across—a variety of countries of the Western world, there is a remarkably stable number of approximately 85 percent of all long-term care that is delivered by family members regardless of the type or duration of official government sponsored long-term care programs.

It is also important to recognize the Canadian example demonstrates something that can also be seen very readily in the European experience, and that is the importance of local control and particularly in a country as large and heterogeneous as the United States what we need to look for is a program that on the one hand provides an adequate base of programs and services across the entire gamut of our service but at the same time recognizes that these services, to be delivered well, need to be delivered flexibly and responsibly by local units, probably in our country something on the order of counties, except in some places that have very large counties like Los Angeles, but manageable, local geopolitical units.

As we look at the Canadian system, we can draw a number of lessons, the most important of which is the program is feasible, it is possible to ask people in positions of responsibility to make decisions about the need for care and to allocate that care, to do it in a way that maintains families as natural support units, not to threaten that kind of support, and to do it within a total expenditure pattern that represents less of the gross national product then we are currently spending without those programs in this country today.

Thank you very much.

Chairman **Stark**. Thank you, Dr. Kane.

STATEMENT OF SANDRA J. NEWMAN, PH.D., ASSOCIATE DIRECTOR FOR RESEARCH, THE INSTITUTE FOR POLICY STUDIES, THE JOHNS HOPKINS UNIVERSITY

Chairman **Stark**. Dr. Newman.

Ms. **Newman**. Mr. Chairman and members of the subcommittee, thank you for the invitation to appear before you today. My name is Sandra Newman, and I am the associate director for research of the Johns Hopkins University Institute for Policy Studies, and also an Associate Professor in the Department of Geography and Environmental Engineering.

My comments today focus on Australia's approach to long-term care and are based on research I conducted when I was a Senior Fulbright Fellow at the Australian National University in Canberra in 1983. Because I undertook this work in the early 1980s, I will be characterizing the Australian system at that time. This represents the first caveat to my comments, which is that they may be somewhat out of date.

I feel two additional caveats or reminders are also in order. The first is an issue of scale: the United States population is roughly 15 times as large as Australia's and its elderly population is 18 times as large. Second, any analysis—cross-national or not—that is based on more than one data source always runs the risk of drawing substantive conclusions that may simply be an artifact of measurement differences. I have made every effort to avoid this kind of error, but it is impossible to guarantee that it has had no effect on any of the estimates or inferences.

Broadly speaking, Australia and the U.S. pose similar contexts for long-term care policy. For example, life expectancy at birth and at age 65, the sex distribution of the elderly, marital status, housing tenure, and the functional limitations of the noninstitutionalized elderly are generally parallel in the two countries. Yet these two nations have taken substantially different policy approaches. Of particular note is the fact that Australia's long-term care continuum contains a larger number of "entries" compared to the United States continuum. Australian Commonwealth nursing home benefits are also broader and more comprehensive than those in the United States.

From the vantage point of the United States long-term care system, five features of the Australian approach may be particularly interesting.

First, with regard to noninstitutional care, Australia has chosen to emphasize in-home care, spending between 50 and 80 percent more on this sector than the United States. In contrast, the United States spends relatively more of its noninstitutional dollars on community-based services, particularly meals programs and other less intensive community services.

Second, although several components of Australia's in-home care sector have broad parallels in the U.S., two elements do not. One is allowances or vouchers to family care givers to defray a portion of the cost of care for their dependent aged relatives, called the domiciliary nursing care benefit. The other is the personal care subsidy which is available to nonprofit providers of special supportive housing for the elderly and handicapped, which the Australians call "hostels."

Third, essentially none of Australia's programs are means-tested. Instead, eligibility is based on medical and health-related need and is established on the basis of certification by a health professional. Overall, Australia's noninstitutional services may be more highly targeted on individuals most at risk for nursing home placement.

Fourth, Australia's nursing home benefits are more comprehensive than those in the United States, having many characteristics of national nursing home insurance. While its level of nursing home expenditures per capita elderly is roughly equal to that in the United States, its expenditures per nursing home resident are lower, seemingly because nursing hours per patient and labor costs are lower.

Finally, the nonprofit sector is singled out for special treatment as the provider of both institutional and noninstitutional care. For example, proprietaries are statutorily excluded from providing in-home care, and the operating deficits of nonprofit nursing homes—which constitute 30 percent of all nursing homes in Australia—are fully subsidized by the Commonwealth.

In view of the wider availability of noninstitutional services in Australia, alongside its broader nursing home coverage and its apparently sharper targeting of noninstitutional care on those at risk of institutionalization, shouldn't its institutionalization rate be lower than that in the United States? In fact, the Australian institutionalization rate is roughly 30 percent higher than that for the United States: 6.8 percent in Australia in 1981 compared to 5.2 percent in the United States in 1980. One possible explanation for Australia's higher rate is that since the demand for long-term care services is very large, providing more noninstitutional services does less for substituting noninstitutional for institutional care than it does for serving previously unmet needs. One lesson to be learned from Australia, then, is that a broader array of in-home care benefits neither substitutes for nor is cheaper than institutional care. Thus, the potential for substitution should not be exaggerated.

Two other considerations must also be taken into account in comparing Australia's overall institutionalization rate with the overall rate in the United States. First, U.S. rates are influenced significantly by constraints on the supply of nursing home beds. Second, since state institutionalization rates vary, comparing overall rates is somewhat misleading.

Perhaps a second general lesson from the Australian experience is that a system with somewhat greater balance between institutional and noninstitutional services appears to be workable and manageable. Uncontrolled growth in the nursing home sector is achieved through a Commonwealth needs assessment—akin, in concept, to the certificate of need approach in the United States—the fact that most noninstitutional programs require State matching dollars apparently achieves control in that sector. Such controls at the State level, however, are achieved at some loss of equity in service availability across states.

Despite these distinct features of the Australian system, Australian long-term care policy, like that in the United States, has not produced a coordinated system of long-term care. There, as here, a variety of programs and services exist that have not developed evenly or as part of a carefully conceived plan. Furthermore, there has been no administrative unit with responsibility for coordinating or managing the care of an individual. In response to this gap, a new Department of Community Services has been created which has policy and administrative responsibility for the full range of long-term care programs, including nursing homes, in-home care, and community-based services. A number of other changes are also in process, including improved and expanded geriatric assessment and greater emphasis on hostels and other supportive housing settings.

Thank you.

[The statement of Sandra J. Newman follows:]

LONG-TERM CARE IN AUSTRALIA

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Testimony prepared for the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, Hearing on Long-Term Care, September 26, 1988.

Mr. Chairman and members of the Subcommittee, thank you for the invitation to appear before you today. My name is Sandra Newman, and I am the Associate Director for Research of the Johns Hopkins University Institute for Policy Studies and also an Associate Professor in the Department of Geography and Environmental Engineering.

My comments today focus on Australia's approach to long-term care, and are based on research I conducted when I was a Senior Fulbright Fellow at the Australian National University in Canberra in 1983.[1] Because I undertook this work in the early 1980's, I will be characterizing the Australian system at that time. Given the rapid pace of significant national policy changes in Australia (in sharp contrast to the U.S.), my comments could potentially be misleading about Australia's current situation. Fortunately, however, the main shifts that have occurred in long-term care policy over the past five years have been organizational and not changes in philosophy, services or subsidies. But whether even these kinds of changes have already produced changes in public sector expenditures or recipient behavior remains an open question.

Broadly speaking, Australia and the U.S. pose similar contexts for long-term care policy. For example, life expectancy at birth and at age 65, the sex distribution of the elderly, marital status, housing tenure, and the functional limitations of the noninstitutionalized elderly are each generally parallel in the two countries. Yet, these two nations have taken substantially different policy approaches. Of particular note is the fact that Australia's long-term care continuum contains a larger number of "entries" compared to the U.S. continuum, such as financial assistance to caregivers and a service-rich version of congregate housing called "hostels," which provide three meals a day plus housekeeping and personal care assistance. Australian Commonwealth nursing home benefits are also more generous and comprehensive than those in the U.S.

How do the outcomes of this more comprehensive long-term care system compare to those in the U.S.? Of particular interest are effects on institutionalization rates and on costs. Neither of these effects is easy to predict. The more generous nursing home benefits in Australia lead to an expectation of more reliance on institutions, but the greater range of noninstitutional care might mean less. Similarly, it is unclear whether the combination of a wider range of noninstitutional services and nursing home coverage should result in higher or lower costs.

In the next section, I will briefly describe the main elements of the Australian long-term care system, focusing primarily on its approach to noninstitutional care. To facilitate comparability to the U.S. system, I will divide the noninstitutional sector into two components: in-home care and community-based care. I will then discuss four outcomes of the long-term care system: costs, rates of institutionalization, quality of care, and service coverage and utilization. In the final section, I will try to derive some implications for the U.S. from the Australian system.

Before proceeding, however, it is important to establish two major caveats. First, the U.S. population is roughly 15 times as large as Australia's and its elderly population is 18 times as large.[2] Second, any analysis--cross-national or not--that is based on more than one data source always runs the risk of drawing substantive conclusions that may simply be an artifact of measurement differences. Care has been taken to avoid this kind of error, but it is impossible to guarantee that it has had no effect on any of the estimates or inferences.

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[1] This research is reported in Sandra J. Newman, Worlds Apart? Long-Term Care in Australia and the United States. (New York: The Haworth Press), 1988.

[2] For a frame of reference, consider the fact that the total population of Australia at about 15 million is about half the size of the elderly population of the U.S.

NONINSTITUTIONAL CARE IN AUSTRALIA

In-Home Care

Six separate funding streams created by Commonwealth legislation subsidize long-term care services delivered to the aged in their own homes. These include:

1. Home Nursing, which consists of skilled nursing care and personal care prescribed by a physician;
2. Domiciliary Nursing Care, through which family members are subsidized by the Commonwealth to care for their aged relatives who have been certified as eligible for nursing home admission;
3. Paramedical Services, which include chiropody, speech therapy, and physio-therapy provided in the aged person's home;
4. Home Care, which brings housekeeping, chore, repair and other domestic assistance mainly to aged recipients;
5. Capital Subsidies for Service-Rich Residential Development, including retirement villages, homes for the aged and hostels (which provide residents with three meals per day, housekeeping assistance and, when necessary, personal care assistance); and,
6. Personal Care, through which all hostel residents 80 years of age or older, and those younger than 80 who have a medical need, are automatically entitled to assistance with activities of daily living (like dressing and bathing) and instrumental activities of daily living (like managing money and doing laundry).

Six features of these programs seem most salient from the perspective of the U.S. system.

-- First, with regard to financing, two programs--the Domiciliary Nursing Care Benefit paid to family caregivers, and the Personal Care Subsidy available to residents of hostels--are funded entirely by the Commonwealth. The remaining programs are matching grants with states, localities or provider organizations, with the match varying between 2:1 to 1:1. The programs funded either through annual appropriations (Paramedical), full entitlements (Domiciliary Nursing Care Benefit, Personal Care Subsidy) or limited entitlements[3] (Home Nursing, Capital Subsidies and Home Care);

-- Second, none of these benefits is means-tested as we define it in the U.S. The Hostels Program (and, therefore, the Personal Care Subsidy attached to it) is the one possible exception, but the wording of the enabling legislation reads more like the U.S. Older Americans Act, suggesting that consideration be given to those in the greatest economic and social need;

-- Third, most of the programs base recipient eligibility on the certification of a health professional (either a physician, nurse, or other health practitioner);

-- Fourth, the states play a key role in determining both the nature and extent of most of these programs including eligible recipients, service providers, and services as well as the number of persons who can be served;

-- Fifth, the ability to charge user fees only comes into play in two programs: Home Care and Service-Rich Residential Developments. In the case of service-rich housing, two kinds of recipient payments are possible: key fees or donations from incoming residents, and weekly carrying costs set at 85 percent of the age pension (plus any supplementary assistance the individual may receive);

-- Sixth, nonprofit organizations are singled out in the enabling legislation as the sole eligible service providers for all components of in-home care (except the Domiciliary Benefit, which is paid to family members). Proprietary providers, therefore, are statutorily excluded from receiving subsidies for in-home care services.

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[3] Limited only by the willingness of states to provide necessary matching dollars.

Focusing solely on the types of programs that comprise Australia's in-home care sector, several have at least broad parallels in the U.S. But at least two components appear to be unique.

The first is the Domiciliary Nursing Care Benefit. For nearly 20 years, the Commonwealth has provided allowances or vouchers to family caregivers to defray a portion of the costs of caring for their dependent aged relatives outside of institutions. To be certified for this benefit, the caregiver must apply to the Commonwealth Department of Health and provide medical verification that the elderly person would be admitted to a nursing home if home care were not available. Eligible caregivers are adult relatives living in the same house with the dependent aged person.

The U.S. tax code provision which currently allows about a $1900 exemption for a dependent in the household bears some resemblance to this Australian benefit. But the U.S. provision has more restrictive eligibility requirements and the amount of the subsidy is about half as generous. The individual claiming the exemption must provide at least 50 percent of all support received by the dependent, and the value of the exemption depends on the filer's marginal tax bracket. Assuming the top marginal tax rate of 33 percent, this exemption is currently worth about $US627; the average benefit in Australia in 1983 was about 50 percent higher at roughly $AUS964 (or about $US1090).[4]

A second unique component in Australia's home care system is the Personal Care Subsidy which, as noted, is available to hostel residents. Nonprofit providers of hostel housing and services apply to the Commonwealth Department of Social Security to receive funding for the delivery of personal care services to hostel residents.

Community-Based Care

The Australian Commonwealth subsidizes four community-based care programs: senior citizen centers, adult day care centers, case managers (called "welfare officers" in Australia) and dwelling unit modifications as well as personal aids and equipment for the impaired. As with in-home care, eligible providers are restricted to nonprofits and local governments. All services, with the sole exception of aids and dwelling modifications, are Commonwealth matching grants either to the state or directly to service providers. As in the U.S., none of these community-based services represent income-tested benefits.

Three aspects of Australia's community-based care system are noteworthy. First, Commonwealth legislation provides for deep subsidies to senior citizen centers and adult day care centers. In both cases, the Commonwealth can cover two-thirds of the capital cost of constructing, expanding or physically improving the facility. In addition, in the case of day care centers, the operating deficits can also be fully covered by the Commonwealth.

A second distinctive component is the "welfare officer" or case manager subsidy, funded by a 1:1 match between the Commonwealth and the state or local government or nonprofit organization.

Finally, under the Program of Aids for Disabled People, the Commonwealth makes annual appropriations to the states to cover the purchase or rental of equipment and the cost of housing modifications such as handrails and grab bars for medically-certified applicants. In the U.S., while Medicare and Medicaid programs have provisions for the coverage of equipment such as wheelchairs, this benefit requires cost-sharing under Medicare and means-testing under Medicaid. Neither program provides any coverage for home modifications.

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[4] Conversion based on 1981 exchange rates.

INSTITUTIONAL CARE IN AUSTRALIA

Australia's coverage of nursing home care approaches national nursing home insurance. Any aged person admitted to a nursing home, regardless of income, is required to pay a minimum statutory contribution or coinsurance that is set at 87.5 percent of the single-person age pension plus supplementary assistance (which averaged $AUS71.75 per week in June 1982); the Commonwealth covers essentially all of the remaining costs. The only exception to this scheme arises when private nursing homes (roughly 48 percent of all nursing homes in Australia) charge additional approved fees which patients must pay out-of-pocket.

The special treatment of the nonprofit sector in the Australian long-term care system is vividly demonstrated by its nursing home policies. Approved nonprofit nursing homes, which comprise about 30 percent of all homes, qualify for deficit-financing under which the Commonwealth subsidizes the operating deficits and the cost of approved asset replacements of participating homes. In addition, patients in deficit-financed homes pay only the minimum statutory contribution; no additional charges are allowed regardless of recipient income or additional services that may be provided. Finally, private nonprofit homes are also singled out for Commonwealth subsidies of the capital cost of building, purchasing or expanding a nursing home. The Commonwealth provides 2:1 matching grants for these capital projects.

OUTCOMES

Costs

Adjusting for differences in the size of the population 65 and older in Australia and the U.S., total expenditures on these three sectors of the long-term care system are roughly equal in the two countries. The nursing home sector also dominates expenditures in both countries: they represent roughly 80 percent of all long-term care spending in Australia and 72 percent in the U.S.

But there is a major difference in the distribution of expenditures between the two components of noninstitutional care. Australia emphasizes in-home care, devoting nearly one-fifth of its long-term care expenditures to this sector, compared to roughly 10 percent in the U.S. As a rough approximation, this translates into a 50 to 80 percent greater expenditure on in-home care in Australia relative to the U.S.

Rates of Institutionalization

Although levels of spending on institutional care in Australia and the U.S. are similar, rates of institutionalization are not. Roughly 6.8 percent of the Australian elderly lived in long-term care institutions in 1981. This institutionalization rate is roughly 30 percent higher than that for the U.S., where the rate in 1980 was 5.2 percent.

The higher institutionalization rate in Australia may be associated with three factors: (a) the greater growth in the nursing home bed supply over the decade; (b) a somewhat greater reliance on institutions for elderly persons without functional incapacities; and (c) the lower incomes of Australia's elderly, possibly making the deep subsidies associated with nursing home care worth relatively more to Australians, on average, compared to the U.S. elderly.

Quality of Care

Since I have already noted that total expenditures per capita elderly on the nursing home sector are essentially similar in Australia and the U.S., the higher rate of institutionalization in Australia must mean that its expenditures per elderly nursing home resident are lower. Data on expenditures per recipient bear this out: in 1981, the average government nursing home expenditure per recipient in Australia was about $4074, while in the U.S., it was roughly $AUS4378.[5]

Although expenditure data may be a poor measure of quality, a more direct measure--average nursing hours per patient--points to the same conclusion since nursing hours per patient are about 25 percent higher in the U.S.

Noninstitutional Service Availability and Use

Depending upon the restrictiveness of the criteria used, Australia serves between about five and nine times as many elderly with in-home service programs. Although it also appears to serve substantially more elderly through its community-based senior citizen centers, it serves many fewer elderly through other community-based programs such as meals programs. Australia has clearly chosen to concentrate its resources on a fairly intensive set of services that provide in-home assistance to elderly persons with health and personal care needs. In contrast, the U.S. directs more of its noninstitutional dollars toward less intensive services consisting mainly of meals served in community settings, some of which are not directed to persons needing long-term care but simply in-kind transfers to healthy older persons.

CONCLUSIONS AND IMPLICATIONS

From the vantage point of the U.S. long-term care system, five features of the Australian approach may be particularly noteworthy.

First, with regard to noninstitutional care, Australia has chosen to emphasize in-home care, spending between 50 and 80 percent more on this sector than the U.S. In contrast, the U.S. spends relatively more of its noninstitutional dollars on community-based services, particularly meals programs and other less intensive community services.

Second, although several components of Australia's in-home care sector have broad parallels in the U.S., two elements do not. One is allowances or vouchers to family caregivers to defray a portion of the costs of care for their dependent aged relatives, called the Domiciliary Nursing Care Benefit. The other is the Personal Care Subsidy which is available to nonprofit providers of special supportive housing for the elderly and handicapped, called hostels.

Third, essentially none of Australia's programs are means-tested. Instead, eligibility is based on medical and health-related need, and is established on the basis of certification by a health professional. Overall, Australia's noninstitutional services may be more highly targeted on individuals most at risk for nursing home placement.

Fourth, Australia's nursing home benefits are more comprehensive than those in the U.S., having many characteristics of national nursing home insurance. While its level of expenditures per capita elderly are roughly equal to the U.S., its expenditures per nursing home resident are lower seemingly because nursing hours per patient and labor costs are lower.

Finally, the nonprofit sector is singled out for special treatment as the provider of both institutional and noninstitutional care. For example, proprietaries are statutorily excluded from providing in-home care, and the operating cost deficit of nonprofit nursing homes (30 percent of all nursing homes in Australia) are fully subsidized by the Commonwealth.

In view of the wider availability of noninstitutional services in Australia alongside its more generous nursing home coverage and its apparently sharper targeting of noninstitutional care on those at risk of institutionalization, shouldn't its institutionalization rate be lower than that in the U.S.? In fact, the Australian institutionalization rate is roughly 30 percent higher than that for the U.S. (6.8 percent in Australia in 1981; 5.2 percent in the U.S. in 1980). One reasonable explanation for these rates is that since the demand for long-term care services is very large, providing more noninstitutional services does less for substituting noninstitutional for institutional care than it does for serving previously unmet needs. One lesson to be learned from Australia, then, is that a broader array of in-home care benefits neither substitutes for nor is cheaper than institutional care. Thus, the potential for substitution should not be exaggerated.

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[5] Represents a weighted average of Medicaid and Medicare nursing home expenditures.

Two other considerations must also be taken into account in comparing Australia's overall institutionalization rate with the overall rate for the U.S. First, U.S. rates are influenced significantly by constraints on the supply of nursing home beds. Second, the overall average institutionalization rate is probably a misleading indicator since state institutionalization rates deviate from it substantially. Thus, Australia's rate is much higher than some U.S. state rates, but much lower than others.

Perhaps a second general lesson from the Australian experience is that a system with somewhat greater balance between institutional and noninstitutional services is workable and manageable. Uncontrolled growth in the nursing home sector is achieved through a Commonwealth needs assessment (akin in concept to the Certificate of Need approach in the U.S.); the fact that most noninstitutional programs require state matching dollars apparently achieves controls in that sector. Such controls at the state level, however, are achieved at some loss of equity in service availability across states.

Despite these distinct features, Australian long-term care policy, like that in the U.S., has not produced a coordinated system of long-term care. There, as here, a variety of programs and services exist that have not developed evenly or as part of a carefully conceived plan. Furthermore, there has been no administrative unit that holds responsibility for coordinating or managing the care of an individual. In response to this gap, a new Department of Community Services has been created which has policy and administrative responsibility for the full range of long-term care programs including nursing homes, in-home care, and community-based services. A number of other changes are also in process including improved and expanded geriatric assessment and greater emphasis on hostels and other supportive housing settings.

Chairman STARK. Thank you very much. Mr. Gradison.

Mr. GRADISON. I don't have any questions.

Chairman STARK. Mr. Pickle.

Mr. PICKLE. Let me ask the Canadian representative, when you take care of costs in a province and it is based largely on the funding, or Federal funds are allowed or given to that particular province, what happens when the money runs out?

Dr. KANE. The funding is not based on the amount of money given by the Federal Government. The money is in fact primarily provincial dollars to which there is a fixed amount given as part of a block grant from the Federal dollars.

Most of the provincial programs work off a fixed base budget in which they try to allot a certain amount to the long-term care sector. As with any other program, they have to shuffle money from one sector to another. There is an overall constraint on a balanced budget in most of those provinces, and they may have to shift coverage from one sector—roads, education, or other things—into long-term care. Generally, they have been able to hold the line on the cost of long-term care.

Mr. PICKLE. I presume if they don't have funds to admit somebody else into a long-term home care program, they just don't admit them, they wait until they have money to do that, is that correct?

Dr. KANE. As far as the experience goes, the waiting list for long-term care in Canada across the provinces we have looked at is less than it is in this country, so that has not been a practical problem there. What has happened is that they are able to shift resources, to take better advantage of community-based services when there is a backlog in the nursing homes. As community services have been developed, there have been fewer backlogs in those nursing homes.

Mr. PICKLE. I don't know I understand you. You say if they do run out of funds, there is a shifting of funds from different categories over into this area of care?

Dr. KANE. That is right.

Mr. PICKLE. Does that usually happen?

Dr. KANE. No. They have been able to manage their funds by controlling the supply of nursing home beds and by providing to local agencies fixed amounts of dollars on an annual budget basis and have been able to run these programs in a balanced budgeted way.

Mr. PICKLE. Thank you.

Chairman STARK. Mr. Coyne.

Mr. COYNE. Thank you, Mr. Chairman.

Dr. Kane and Dr. Newman, would you please assess the quality of the programs in Canada and Australia. Was it satisfactory? Would we be able to have satisfactory quality given the population of the United States?

Dr. KANE. Well, there are two separate questions there, so let me take them in order. First, quality assurance practiced in Canada is quite different from quality assurance practiced in this country. People have remarked that the Canadian view of the role of government is quite different than the American view of the role of government, so in the United States we promise life, liberty and the pursuit of happiness, and the Canadians talk about peace, order and good government. The relationship between the government regulator and private provider is a more cooperative one. We do not find in Canadian provinces the same level of regulatory enthusiasm we find in the United States. If one looks at the quality of care that results, I think we see a higher level of humaneness, along the lines Dr. Williams has pointed out in his testimony.

The issue is how would we see such a program translated then into the American system? We in this country have to deal with a more entrepreneural spirit than we find in the Canadian system, and our regulatory approach ought to be based much more on looking at the outcomes of care and holding the providers of care responsible for the degree to which reasonable levels of expected care are achieved and building that into the payment system as a basis of direct accountability.

What we have done in this country, in fact, is to capitulate to professional orthodoxies by writing standards very much based on the particular judgment of individual professions in terms of hours of care per profession per person, which do not necessarily correlate with any kind of outcome measures.

What we should be seeking is an environment like the one Dr. Williams describes, based on humaneness and compassion, but these are very difficult to regulate. One hour of compassionate care may be worth more than 20 hours of belligerent care, and yet we have never written a regulation in this country that talks about compassion. We talk about the need to have dieticians supervise meals, there is no regulation about the food tasting good.

It seems to me we have our priorities out of order. We ought to be thinking what we are trying to do with long-term care rather than simply measuring it.

Ms. **Newman**. There are obviously many parallels between the Australian and Canadian systems, which I am sure are clear to you from Dr. Kane's and my testimonies. With regard to quality of care, in my attempts to account for the lower cost per nursing home resident in Australia, I turned immediately to quantifiable aspects of quality of care such as hours per patient, staff to resident ratios, and so forth. While I could only get data on a very small subset of these attributes, it is obviously the case that none of these measures, nor comparable measures for the United States, have anything to say about the actual treatment of patients, the relationship between patient and caregiving and other facets of what most people probably mean by quality of care and quality of life in nursing homes. Such attributes are harder to measure and, of course, harder to regulate and legislate.

Mr. **Coyne**. Have you given much thought to what jurisdictions would deliver this type of service throughout the United States? Given that we have 3,200 or 3,300 counties in the United States, is it feasible to think it could be local jurisdiction?

Dr. **Kane**. The answer to that depends on the size of the counties. We have a tremendous number of counties, and they vary in size. I don't think one can simply pick a particular political jurisdiction and say that will be it. I think we ought to be looking at population bases on the order of 200,000 to 1 million people.

Dr. **Williams**. I can comment on that from an experience 10 years ago in south Australia. In south Australia I was very much impressed with the fact that they had a catchment area approach for long-term care. South Australia, with a population of about a million people, was divided into four geographic catchment areas, each of which had a lead agency. This was all mostly within the governmental jurisdiction of the city of Adelaide, but covered 90 percent of the population of south Australia.

These catchment areas, in my view, functioned very well in terms of care management responsibility for determining need, allocating the resources, operating it, and using various agencies. I was very much impressed with that, and I don't know whether your experience would coincide with that model or not.

Ms. **Newman**. Not on that point particularly, but the one thing I think really does need to be considered in thinking about the best delivery agent for these services is the unevenness of experience, capability, and infrastructure for doing this across the country. This is true not only in long-term care but many other areas, and it is a major challenge to ensure that all recipients are treated equally, which requires that those who are delivering care also have some common base.

Mr. **Coyne**. Thank you very much.

Chairman **Stark**. Well, I rarely have to say that I am disappointed in testimony, but I would have to say it for this panel. I was so looking forward to visiting Sweden, Denmark, Australia and finding out what their long-term health care systems were like. You have done such a good job explaining them, I can't charge the taxpayers for my trip. I will just have to check and find out vicariously through the panel.

Seriously, you did a service, at least for me, in explaining these systems. I gathered the sense that most of these countries deal with the problem of long-term care more through an environmental or social situation than through the traditional hospital, doctor and nurse. Therein is a kind of different emphasis on long-term care than we have in this country. Whether it would work or not, remains to be seen.

Do any of these countries have an overt conscious effort to rehabilitate residents in hostels or in nursing homes and then to move people out? Or is there just a kind of acceptance at some stage in your chronology of life that you just become a resident in one of these programs?

Dr. **Williams**. They certainly give a high priority to rehabilitative efforts, and they have a reasonably high success rate. I can't give an exact figure, but some figures are given in the reports I have provided, and they emphasize a rehabilitation goal.

I think we can certainly do the same in this country. It is not for everybody, obviously, but there can be a considerable amount of success. Dr. Brody mentioned the high percentage of people who actually, in our country, don't stay in the nursing homes indefinitely.

Dr. **Kane**. Certainly in Canada, just as in this country, there is a very strong presence of rehabilitation. I would urge that we recognize the Canadian system is not that dissimilar from the American system, and we have the same tensions between the medical and social phenomenon, and indeed one of the problems that remains in Canada, as here, is that linkage between acute and long-term care, particularly over the issues of rehabilitation where they do maintain rehabilitation care units within the hospitals and there is a jurisdictional squabble as to who covers that.

The advantage is that it all is coordinated at a higher level through a single ministry, and many of these problems can be addressed at the level of policy. One of the great problems we face in this country is that it is very difficult to make decisions about individuals when it comes to giving or withholding care. And those decisions really need to be made as policy decisions at some level removed. We don't have that opportunity here because we have so fractionated our care system; if you don't get what you want in one place, you seek another. We lost a handle on the system to begin to deal with these types of issues.

Ms. **NEWMAN**. I think that is exactly the kind of problem that generated the introduction in Australia of the Department of Community Services which brings together under an administration structure the Department of Health programs and the Department of Social Services Social Security programs.

Chairman **STARK**. Let me come back to Dr. Kane. Are you suggesting, and I think maybe you are, that because of the individuals involved with the person who is ill or elderly, there is such an emotional attachment that we are not apt to make sound economic judgments? Are you just saying that these countries are not more heartless but closer to the triage sort of bureaucratic approach, because they coordinate all this, than the U.S. softies here?

Dr. **KANE**. No. I think it is a false dichotomy. I would say, if anything, the Canadian system is more humane than the American system. We make these decisions all the time in the United States. We refuse to acknowledge these people exist. We just don't pay for their care. We basically cross them off.

What the Canadians have done, because they have a universal base, is to be responsible for the denominator and make those kinds of decisions. The only way to control utilization in the Western world is frankly through supply. We need to make decisions about how many nursing homes we are going to build, how many doctors we are going to train. We are not in this country prepared to plan with dynamite. If we don't take it out of service, we continue to utilize it.

We made some major policies through things like the DRG system that have had a profound effect on the way we practice. We need to look at the whole range of people being served by a program and make some of the difficult decisions about whom we are really prepared to serve with what, to give people at the local level adequate resources to provide a reasonable level of care but to recognize that there is no limit to the amount of care one could give in these is no resource constraint. Limits on the amount of care to be given are better set on a population basis, not on one-by-one incidents.

What happens is exactly the kind of question I was asked earlier. You are ready to go in January, and by November you are running out of resources, so essentially you ration on the basis of calendar year rather than rationing on the basis of need.

Dr. **Williams**. I would like to comment on this. I have had a good bit of experience in following and working with experimental and demonstration projects in long-term care in this country. One of the comments Dr. Kane made earlier concerns the critical problem we have and that is the division of care into various boxes paid for by different sources: hospitals, doctors, nursing home, and home care. I think this is where we really waste our money.

A number of the long-term care studies that have been done, and Congressman Gradison is familiar with one in Rochester, NY, have shown over and over that if there is an organized, comprehensive system, we save money on hospital care. We can avoid the high expense of hospital care quite appropriately by doing the right thing by the patients. Contrary to the view that care is an unending open benefit, I think where the range of care is part of a comprehensive approach dealing with all elements of care, the best decisions don't lead to the use of unending resources, I think they end up using much more appropriate resources, as well as fewer resources. Our problem is to get our care into a comprehensive, interrelated system all managed in the way we are hearing about from Canada and Australia.

Chairman **Stark**. Again, I want to thank the panel. it has been most interesting. I hope we can counsel with you as we work our way through this problem.

Our third panel consists of Dr. Mark Meiners, Ph.D., director of the Robert Wood Johnson Foundation Program to Promote Long Term Insurance for the Elderly; Dr. Kevin J. Mahoney, Ph.D., principal investigator for the Long Term/Medicaid Program for the State of Connecticut; and Mr. Howard Berman, chief executive officer for the Blue Cross and Blue Shield Association of the Rochester area. Dr. Meiners, you may begin.

STATEMENT OF MARK R. MEINERS, PH.D., DIRECTOR, ROBERT WOOD JOHNSON FOUNDATION PROGRAM TO PROMOTE LONG-TERM CARE INSURANCE FOR THE ELDERLY

Mr. **Meiners**. Thank you for inviting me here today.

I think these are exciting times for those of us who have worked in this area for a long time. I am currently the associate director of economics of aging and health at the University of Maryland. Prior to joining the University of Maryland, I was senior research manager at the National Center for Health Services Research, and directed the long-term care studies program in the intramural research division.

I am here today in my capacity as director of the Robert Wood Johnson Foundation Program to Promote Long Term Care Insurance for the Elderly.

The absence of adequate financing for long-term care has been a public policy concern for many years. Only recently has the notion of insurance for long-term care been introduced into this debate, and I think it is an important introduction, because in the area of long-term care there were two key sources of financing, people paying out of pocket and the medicaid program.

Paying out of pocket is a situation that for many can't last very long and people end up on the medicaid program. To the extent people don't have a way to plan for long-term care, they end up on medicaid. To the extend medicaid has to pay, we are concerned from a public policy budgetary standpoint.

A growing debate has now developed as to the role of insurance options for long-term care. There has been an acceptance across the country of the insurability of long-term care, and I might point out this is a new phenomenon. Less than 10 years ago, the notion of long-term care being an insurable event was pretty much rejected by all parties.

The debate now is, how should we structure this kind of coverage and who should sponsor them?

While many of the proposals have some type of insurance mechanism in common, the benefits, premium structure and proposed sponsors vary quite widely. This variation demonstrates the wide range of possible approaches for insurance program development, and indicates the need to further investigate the possible components of a broad-based insurance program.

In August of 1987, the Robert Wood Johnson Foundation took a major step towards informing—by initiating a program for the development and evaluation of private partnerships. The purpose of the program is to provide those states which have demonstrated a commitment to reforming long-term care financing with the resources to evaluate the potential of private market products and to design demonstration models in which the state will work with insurers to expand the role and comprehensiveness of their products.

Seven grants have been given to date. They have been given in a phased-in basis, under the foundation's Promote Long Term Care Insurance for the Elderly.

Over the last 20 years states have had a major role in shaping the delivery and financing of long-term care services. Not only do they pay for a large portion of the long-term care costs through the medicaid program, they are also responsible for many other aspects of care delivery and reimbursement, including determination of nursing home bed need and community-based provider capacity under the certificate of need program, establishment of a reimbursement methodology for nursing homes and home health care providers, and monitoring the quality of care by all providers. States also administrate several other Federal and State community-based long-term care programs.

By locating the grants in the States, the program takes advantage of the only substantial body of experience with all aspects of long-term care, including benefit determinations through nursing home screening programs, eligibility determinations through the medicaid spend-down process, and initiation of a wide variety of community-based services through 2176 and other waiver programs.

This experience combined with the variation in approaches to long-term care makes the States an ideal laboratory for the development of new financing options. Given the large portion of the States' budgets which are devoted to long-term care, there is a clear incentive to explore new financing methods while maintaining their well-established commitment to long-term care.

The grant program is structured so as to encourage individual States to select conceptual models which best complement their existing financing and service delivery systems while remaining consistent with the program's five overall goals.

First, to develop public-private partnerships to help elders avoid having to become improverished before public benefits begin.

Second, to ensure access to quality services by encouraging appropriate service system supply.

Third, we are looking to have as full a range as possible of home and community services offered to balance the current institutional bias that exists.

And, fourth, we are hoping to control the risk through case management benefit structure. It is viewed as an important mechanism for controlling risk and getting away from some of the more medical determinations which depend on the use of institutional care you have probably heard about with the recent United Seniors Report.

And, finally, we are looking to have the programs designed in a manner such as they provide the opportunity to participate among all income groups.

I have attached to my testimony a brief article that appeared in the May issue of Business and Health in which I spell out what I call a menu of options the States are considering. I would like to highlight there are at least two levels of interest that the States have.

One is what we are talking about, is general market support strategies. Areas the States have already been involved in vary significantly. We are looking to them to restructure and rethink what they are doing to orient it in a way that encourages better planning on the part of the elderly. These include such things as educational campaigns and regulatory review.

Perhaps more importantly, the notion of coordinating their costs and care management mechanism they have in place for the medicaid programs with what the needs of the private market may be, and furthermore, helping to develop the information and data base that can go toward providing sounder actuarial calculations for the products developed so they can be as appealing and affordable as possible.

These are areas the States are already involved in, one way or another, and we are encouraging them to re-orient their thinking.

There is a whole other level the States in our initiative are exploring and that is rethinking the way medicaid dollars are spent and examining whether they can be spent in a way to better leverage the potential of the private dollars being contributed.

As I mentioned before, there is currently a strange public/private partnership in the sense there is an all out-of-pocket expenditure on the part of people who need this care and then medicaid kicks in. We are trying to think through different mechanisms where that might be more reasonable.

I think there will be a need for the support, perhaps medicaid—waivers of current medicaid restrictions to allow the States to go forward to rethink their programs for the elderly.

The Robert Wood Johnson Foundation grant program provides support for States to examine their long-term care systems from an insurance perspective, and for private insurance companies to benefit from the extensive State experience with the delivery and financing of long-term care. To date, this exchange has proven useful for both parties.

Through the course of the planning phase and subsequent demonstration phase, a broad array of insurance components will be evaluated and tested. The results from these grants should be of great assistance to the further development of future long-term care system reform efforts in other States or on the Federal level.

I am happy to have with me today one of the program directors from one of the flagship States in our initiative, Kevin Mahoney. He is going to be able to provide you with more detail as exactly what one State is undertaking under our initiative.

Chairman STARK. Thank you very much for introducing Dr. Mahoney.

[The statement of Mr. Meiners follows:]

THE UNIVERSITY OF MARYLAND
CENTER ON AGING

TESTIMONY OF MARK R. MEINERS, Ph.D

ASSOCIATE DIRECTOR FOR ECONOMICS OF AGING AND HEALTH
CENTER ON AGING
UNIVERSITY OF MARYLAND

and

DIRECTOR, ROBERT WOOD JOHNSON FOUNDATION PROGRAM TO PROMOTE LONG-TERM CARE INSURANCE FOR THE ELDERLY

BEFORE THE

SUBCOMMITTEE ON HEALTH

COMMITTEE ON WAYS AND MEANS

HEARING ON LONG-TERM CARE FOR MEDICARE ELDERLY AND DISABLED BENEFICIARIES

SEPTEMBER 26, 1988

COLLEGE PARK CAMPUS
Room 2304, PERH Building
College Park, Maryland 20742-2611 (301) 454-5393

My name is Mark Meiners and I am the Associate Director for Economics of Aging and Health, University of Maryland Center on Aging. I am here today in my capacity as Director of the Robert Wood Johnson Foundation Program to Promote Long-Term Care Insurance.

The absence of adequate financing for long term care has been a public policy concern for many years. Recently, a growing debate has developed as to the role of insurance options for long-term care; how they should be structured and who should sponsor them. The presence of this debate is nowhere more evident than here on Capitol Hill. The recent legislative session saw numerous proposals for the reform of long-term financing. While many of the proposals have some type of insurance mechanism in common, the benefits, premiums structures and proposed sponsors vary widely. This variation demonstrates the wide range of possible approaches for insurance program development, and indicates the need to further investigate the possible components of a broad based insurance program.

In August of 1987, the Robert Wood Johnson Foundation took a major step toward informing this debate by initiating a grant program for the development and evaluation of public-private partnerships in the creation of long-term care insurance programs. The purpose of the program is to provide those states which have demonstrated a commitment to reforming long-term care financing with the resources to evaluate the potential of private market products and to design demonstration models in which the state will work with insurers to expand the role and comprehensiveness of their products. Seven grants have been given to date, (California, Connecticut, Indiana, Massachusetts, New Jersey, New York, and Wisconsin) under the Foundation's Program to Promote Long-Term Care Insurance for the Elderly.

Over the last twenty years states have had a major role in shaping the delivery and financing of long-term care services. Not only do they pay for a large portion of the long-term care costs through the Medicaid program, they are also responsible for many other aspects of care delivery and reimbursement, including determination of nursing home bed need and community based provider capacity under the certificate of need program, establishment of a reimbursement methodology for nursing homes and home health care providers, and monitoring the quality of care by all providers. States also administrate several other Federal and state community based long-term care programs.

By locating the grants in the states, the program takes advantage of the only substantial body of experience with all aspects of long-term care, including benefit determinations through nursing home screening programs, eligibility determinations through the Medicaid "spend down" process, and initiation of a wide variety of community based services through 2176 and other wavier programs. This experience combined with the variation in approaches to long-term care makes the states an ideal laboratory for the development of new financing options. Given the large portion of the states' budgets which are devoted to long-term care, there is a clear incentive to explore new financing methods while maintaining their well established commitment to long-term care.

The grant program is structured so as to encourage individual states to select conceptual models which best complement their existing financing and service delivery systems while remaining consistent with the program's five overall goals:

- Restructuring the current public-private partnership to avoid requiring elders to impoverish themselves before becoming eligible for public benefits
- Ensure access to quality long-term care services
- Cover the full range of home and community based services
- Establish a case-managed benefit structure
- Design program in such a manner so as to provide the participation of all income groups.

Attached is a brief article entitled "Enhancing the Market for Private Long-Term Care Insurance," that provides further detail on the menu of options the states in our program are considering. It appeared in the May 1988 issue of Business & Health.

The Robert Wood Johnson Foundation grant program provides support for states to examine their long-term care systems from an insurance perspective, and for private insurance companies to benefit from the extensive state experience with the delivery and financing of long-term care. To date this exchange has proven useful for both parties. Through the course of the planning phase and subsequent demonstration phase, a broad array of insurance components will be evaluated and tested. The results from these grants should be of great assistance to the further development of future long-term care system reform efforts in other states or on the Federal level.

BUSINESS AND HEALTH

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Enhancing the Market for Private Long-Term Care Insurance

BY MARK R. MEINERS

States' structures offer inherent strategies for financing and delivering eldercare.

One of the most intriguing aspects of long-term care insurance is the potential it holds for relieving some of the pressure on Medicaid. Elderly persons who need long-term care typically must pay for such services out-of-pocket and quickly become candidates for Medicaid. According to recent analysis by staff of the House Select Committee on Aging, 67 percent of elderly persons 65 years of age and over who live alone and 46 percent of elderly married couples would spend down their income and financial assets to impoverishment within one year of a nursing home stay. By the year 2030, the Department of Health and Human Services (HHS) predicts a 132 percent increase in the number of nursing home residents.

Obviously, government payers will benefit if private insurance can reduce Medicaid's obligations for the middle class elderly by delaying or avoiding this spend down. Private long-term care insurance also can be viewed as an alternative to current incentives to transfer assets to gain Medicaid eligibility. Some elderly, not wanting to forsake their life savings, forfeit their assets to their spouse, children or other close relatives.

Mark R. Meiners is associate director for Economics of Aging and Health, Center on Aging, University of Maryland in College Park, and director of the Robert Wood Johnson Foundation Program to Promote Long-Term Care Insurance for the Elderly.

Targeting States

Although the federal government shares the financial responsibility for Medicaid, states bear much of the responsibility for the structure and administration of their long-term care financing and delivery systems. Medicaid expenditures typically account for a large percentage of states' budgets, and these expenditures have experienced rapid increases due to the significance of Medicaid in paying for long-term care.

Insurance regulation also is a state responsibility. It is not surprising, then, that states have actively begun to explore the roles they might play in fostering private market long-term care initiatives. Connecticut and Massachusetts, for example, recently implemented programs, with grant and technical assistance support from the Robert Wood Johnson Foundation, to design and develop cooperative public-private long-term care insurance partnerships. Similar Robert Wood Johnson Foundation grants have been awarded recently to Indiana, Wisconsin, New York, and New Jersey to support those states' program planning and development efforts (see box).

A Menu of Options

Numerous public strategies can be employed to encourage a private long-term care insurance market. These strategies suggest a menu of options, which can be broken into the four following distinct but related targets for support:

General Market

- Educational campaigns to enhance public awareness;
- Regulatory review to encourage market flexibility;
- Improved data development and sharing to minimize uncertainty;
- Coordination of public cost and care management mechanisms such as utilization review, with those of the private market.

Consumers

- Liberalize asset spend down requirements;
- Tax credits or deductions;
- Deductibles or copay subsidies;
- Inflation protection.

Insurers

- Premium tax relief;
- Public reinsurance programs.

Special Populations

- Buy-in of Medicaid eligibles;
- Special risk pool subsidies.

The first set of options can be viewed as indirect support strategies. They contribute to a receptive environment for market development and emphasize reorientation rather than expansion of current public responsibilities. As such they are both important to market development and relatively easy to implement through adjustments to ongoing public programs and responsibilities.

The remaining categories represent more aggressive strategies in that they involve direct market subsidies, that is, financial incentives for developing long-term care insurance. There are reasons for considering such interventions in the market. Long-term care insurance is in its infancy. While there has been considerable interest in product development the market is small and underdeveloped. The limited market size and conservative pricing in turn tends to restrict the market to relatively high income persons. Thus, targeting subsidies to encourage participation by persons otherwise unable to afford long-term care insurance would increase the long-term care market and lessen the number of persons most likely to spend down.

Subsidy Strategies

As the options menu suggests, market subsidies could be targeted in several ways. One approach is to restructure the Medicaid eligibility criteria to offer a stop-loss guarantee that provides protection from further assest spend down for anyone paying through insurance for a set number of years. This would address the concern that current policies typically do not offer complete catastrophic protection, the maximum coverage being about six years.

Premium subsidies in the form of tax credits or deductions for consumers who buy a certified level of insurance protection also would support market development. Other possible approaches involve subsidizing the required out-of-pocket payments associated with the deductible and copayments of a state supported insurance plan. These types of subsidies are designed to increase the affordability of current products. Both asset waiver and premium subsidy strategies are targeted to the consumer and can be varied on the basis of income.

Another possible consumer oriented subsidy strategy would be a public program that underwrites a portion of inflation in the cost of care that exceeds some "reasonable rate" for purchasers of policies with such inflation protection. This type of subsidy might encourage more insurers to include inflation protection. It provides a way to formalize the inevitable stake public payers have in dealing with increases in the cost of care.

While consumers are certain to benefit from such strategies, insurers benefit indirectly from strategies designed to enhance consumer interest and policy affordability. Subsidy strategies targeted directly to insurers could be in the form of premium tax breaks or public reinsurance programs to help insurers overcome their hesitancy to enter or expand the market. The latter option in particular could be helpful.

There are numerous sources of uncertainty that insurers must allow for in their product design and pricing decisions. The dynamics of long-term care utilization and cost patterns are only beginning to be understood. Changes in morbidity patterns, formal and informal care systems, and technology are some of the factors that can affect these patterns in unanticipated ways.

Carefully crafted, however, a public reinsurance program designed to share some of these risks with private market insurers could help insurers overcome their hesitancy to share information on utilization and cost patterns under their programs.

States also might assist in market development by paying the premium for persons eligible for Medicaid on the basis of a certain low income level or by establishing special subsidized insurance risk pools for those who would otherwise be uninsurable. This strategy would broaden the risk and help spread administrative costs.

No One Approach

There is no one approach to market support that is clearly best at this stage of development. Depending on specific market characteristics, a state might choose to use one or several of these strategies. For most of the strategies mentioned above, federal waivers would be necessary to allow states to restructure the way Medicaid dollars are spent. The uniqueness of a state's Medicaid eligibility criteria in addition to its regulatory approach to long-term care insurance will influence the program design most likely to be acceptable. A state's fiscal outlook and political climate also will influence whether strict budget neutrality will be the measure of feasibility and success or whether the benefits of paying for long-term care will be viewed as worthy of more resources.

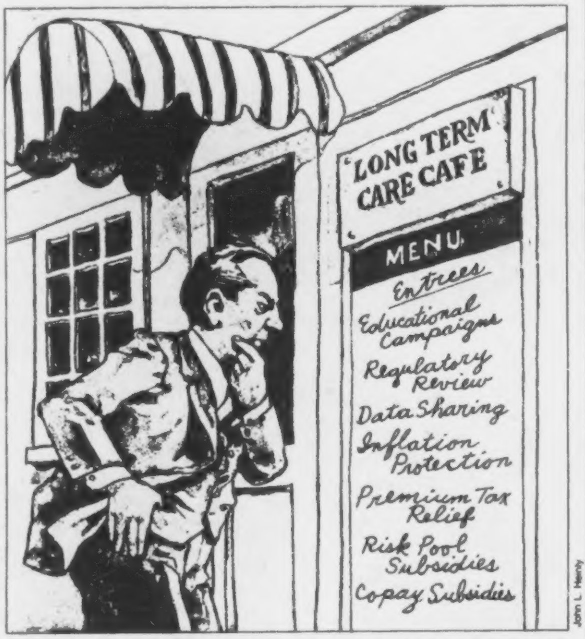
Insurance Support

One approach that incorporates some of these considerations is an insurance support program being examined in Massachusetts. The model is structured around three critical components: a deductible period; an insurance pool; and a stop-loss agreement. The insurance pool would be designed to be affordable by a large segment of the population.

To accomplish the goal of widespread affordability, a significant deductible period would be required (for example, one year or an equivalent dollar amount) and the coverage would be limited (for example, two years or an equivalent dollar amount). Payment of the deductible would vary by ability to pay subject to a lifetime cap, with the residual subsidized by the government. A copayment would be charged. For those who purchase the required insurance coverage, the current Medicaid asset test would be adjusted to allow a greater amount of the individual's resources to be protected.

Program participants would be responsible for paying the deductible out-of-pocket payment, although it also could be covered with supplemental insurance. The deductible would be subsidized on the basis of income. The idea is to offset the extra cost of the subsidies with the insurance induced savings to public programs by delaying or avoiding the process of spend down.

The details of the model and underlying utilization and cost implications are now being examined to accom-



John L. Heinly

plish the necessary balance between two goals: an insurance policy that is affordable by a large segment of the population, most important, a large segment of those who would otherwise spend down; and a policy that maximizes the amount of the total risk that can be covered by the insurance program.

An Alternative Model

In Connecticut, the most discussed market support model has a waiver of the asset spend down approach as the primary subsidy strategy. It is recognized, however, that the specifics of the waiver of asset spend down criteria will need to be carefully considered.

The implicit assumption here is that few people can pay privately for much more than two to three years of care and that those who could pay find ways to protect their assets from Medicaid by the time they use services for an extended period. While this may be the case, there is sentiment for tightening Medicaid rules on transfer of assets and other resource protection strategies once consumers have better options for protecting themselves from the financial risk posed by long-term care.

While asset protection is certainly an important consideration in successfully marketing long-term care insurance, there may be limits to what makes sense from a public policy point of view. Those who benefit the most are those most likely to have resources after two to three years, either because they could afford insurance protection or could pay out of pocket for that amount of time.

One possible argument for not trying to cap the asset protection amount concerns the ease of program administration. Asset transfer and divesture rules are difficult and controversial to administer.

Moreover, persons with high income and assets may have a lower than average risk. In that case persons with high income may need extra encouragement to be part of the general risk pool.

An alternative to full waiver of asset spend down would be to cap the amount of assets that could be protected at some "reasonable" level. Connecticut is examining the possibility of setting the level on the basis of the amount of insurance protection purchased by the consumer. For example, if a policy provides $25,000 in long-term care protection, the state would guarantee the purchaser for protection for up to $25,000 of his or her assets and still attain Medicaid eligibility.

By directly linking the amount of protection that is purchased with the amount of asset protection that the state will guarantee, this approach encourages insurance options that are affordable by consumers with different levels of resources to spend as well as to protect.

Details Need Resolution

Before a long-term care insurance program is taken on, many details need to be resolved. Some issues for consideration include: deciding whether Medigap in addition to long-term care insurance should be purchased in order to qualify; determining the state's minimum standards that would qualify a policy as adequate for the program and how those standards are integrated with the state's Medicaid requirements; agreeing on the age at which participation should begin; and categorizing the level and type of assets a person is allowed to maintain, such as whether the level of liquid assets retainable should differ by family size and whether to consider the home equity value as part of what is protected.

Collecting Spend Down Data

The extent to which a state chooses to be aggressive in fostering risk pooling options may depend on the degree to which divestiture and spend-down occur.

Whether there will be sufficient delay or avoidance in the use of Medicaid to justify direct support for insurance options will depend on who buys the protection, who actually uses long-term care services and the extent to which users require Medicaid assis-

[redacted]

tance. Strategies to subsidize the market may be quite costly relative to the current approach if they are not carefully targeted.

To develop, cost out and analyze options for leveraging Medicaid dollars with private dollars in a way that provides consumers with protection against catastrophic long-term care expenses, data to answer the following set of core questions are important: How many long-term care patients start out as private pay? How many private-pay patients spend down to Medicaid eligibility? How long did it take them to spend down? Once they have spent down, what part of the bill do they pay vs. what Medicaid pays? What are the utilization and expenditure patterns over time of those who have spent down compared with those who were Medicaid eligible from the beginning of their spell of illness?

Arguments for Action

The growing recognition of long-term care as an important and insurable risk has prompted considerable interest in developing a private market for this type of protection. Consumers would benefit if risk pooling mechanisms can be developed. By participating, they might avoid the current all-or-nothing situation with Medicaid that requires them to be impoverished to receive help. Delaying or avoiding the spend down process also could save public dollars. For those with resources, widespread and affordable insurance options would provide an alternative to the current incentive to protect those resources from Medicaid claims by transferring them to relatives. To the extent that divestiture and spend down by the middle-class can be avoided when elderly consumers purchase long-term care insurance, Medicaid can better serve its intended purpose of helping the poor. ■

Chairman **Stark**. Dr. Mahoney.

STATEMENT OF KEVIN J. MAHONEY, PH.D., PRINCIPAL INVESTIGATOR, LONG-TERM CARE INSURANCE PROJECT, STATE OF CONNECTICUT

Mr. **Mahoney**. Thank you very much for the chance to appear before you today. My name is Kevin Mahoney. I am the principal investigator for Connecticut's long-term care insurance program.

In June of 1987, Governor O'Neill's Commission on Private and Public Responsibilities for Financing Long-Term Care for the Elderly issued its final report. The first recommendation called for the development of a model using public and private funds cooperatively to finance long-term care.

To meet this goal, Connecticut applied for and received one of the first Robert Wood Johnson Long-Term Care Insurance Program grants. Our 2-year planning period got under way in August 1987. Under this grant, we have developed a model which provides comprehensive coverage and allows individuals to meet their long-term care needs in a dignified way. This approach promises to save Federal and State dollars, but we will need Federal legislation to demonstrate these benefits.

In my brief time before you today, I would like to describe our model, its merits and the specific legislation we need.

We have been aided in our work by a broad-based steering committee. We are involving people from State government, senior citizen groups, from the health care delivery system and from the private insurance industry. This cooperative approach has in and of itself been one of the most important achievements of this project.

Connecticut's model, which has come to be called the Connecticut Partnership for Long-Term Care, would encourage individuals to plan for long-term needs by purchasing long-term care insurance protection in an amount commensurate with their assets. Thus an individual with $50,000 in assets might buy $50,000 in insurance protection while an individual with $250,000 might want to buy $250,000 or thereabouts in insurance protection.

If and when an individual exhausts his or her insurance benefits, he or she can apply for medicaid and each dollar that the insurance policy has paid out in accordance with State policy will be subtracted from the assets the individual still has so that those assets would not be recognized or considered in determining the individual's financial eligibility for financial assistance.

In other words, insurance payments for long-term care services would be considered as equivalent to the spending of assets for the purpose of establishing medicaid eligibility.

Once on title XIX, individuals would be able to keep control of assets up to the amount that insurance paid, income would still have to be applied towards long-term care expenses.

Some of the merits that we have seen in this approach could be described as follows. It provides individuals with a way to prevent impoverishment. It extends means-sensitive assistance; the rich would never automatically get publicly financed care as in some proposals currently before the Congress. Those who qualify for the public program will have assets that they would have otherwise exhausted, and persons of limited means will find insurance more affordable because they would be able to purchase lower amounts of asset protection.

This model could stimulate private insurers to develop products for a wider market, for the poor as well as for the rich. The Connecticut Partnership of Long-Term Care appears to save Federal and State funds, in simulations done to date, by as much as 11.9 percent a year in the period 2016 to 2020.

Also, this approach influences the types of coverage offered under private long-term care insurance. As you see in our written testimony, we are speaking of pre-certifying policies or specifying the conditions under which they could count towards medicaid eligibility. Pre-certification would only be available to policies which offer comprehensive care while discouraging inappropriate utilization. The conditions under which precertification would be available deal with many of the flaws consumer groups have pointed out in some of the insurance products that have been offered to date.

If we are to be able to demonstrate and evaluate this model, it appears that Federal legislation would be necessary. Such legislation would have to do three things. First, provide the mandate for a HCFA demonstration, including a number of States, perhaps up to eight States, to test the cost-effectiveness of these public/private models.

Second, it would authorize these States to amend their medicaid regulations to specifically allow the States to disregard assets equal to the approved long-term care insurance expenditures.

And, third, and very important, would have to provide lasting assurance that anyone who purchases long-term care insurance during the demonstration will be able to protect their assets equal to the approved long-term care insurance payments, that is if and when they needed medicaid assistance.

Thank you very much.

[The statement of Mr. Mahoney follows:]

STATE OF CONNECTICUT
OFFICE OF POLICY AND MANAGEMENT

THE CONNECTICUT PARTNERSHIP FOR LONG TERM CARE: THE MODEL; ITS MERITS; AND A LEGISLATIVE PROPOSAL

Testimony of
Kevin J. Mahoney, Ph.D.
Principal Investigator, Long Term Care Insurance Project

Presented before the

SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

September 26, 1988

Telephone (203) 566-8340

Mr. Chairman and Members of the Committee, I am Kevin J. Mahoney, Ph.D., Principal Investigator for The State of Connecticut's Long Term Care Insurance Project.

HISTORICAL BACKGROUND

In June of 1987 Governor O'Neill's Commission on Private and Public Responsibilities for Financing Long Term Care for the Elderly issued its final report. The first recommendation called for the development of an economical, feasible, practical, mutually-beneficial model using public and private funds cooperatively to finance long term care.

To meet this goal Connecticut applied for and received one of the first Robert Wood Johnson "Long Term Care Insurance Program" grants. Our two year planning period got underway in August, 1987. Under this grant we have developed a model which provides comprehensive coverage and allows individuals to meet their long term care needs in a dignified way. This approach promises to save federal and state dollars, but we will need federal legislation to demonstrate these benefits. In my brief time before you today I would like to describe our model, its merits and the specific legislation we need.

BROAD-BASED STEERING GROUP: A REAL PARTNERSHIP

At the beginning of our planning process, we established a Policy Steering Committee - composed of representatives from:

- state government
- the legislature
- senior advocacy groups
- academia
- the health care delivery system
- the private insurance industry
- major employers

This cooperative approach has, in and of itself, been one of our major accomplishments.

OBJECTIVES

The Steering Committee began its work by trying to specify the public policy objectives. We agreed that the public/private financing model should:

- Reduce the incidence of impoverishment of individuals and families, offering individuals the opportunity to avoid spending down all their assets, but requiring individual responsibility and action.
- Promote equal access to a comprehensive range of services:
  - regardless of disability or income;
  - maximizing client autonomy/choice; and
  - incorporating a financing system which is simple to understand and administer.
- Increase the use of formal private financing vehicles which allow individuals to rationally plan ahead to meet long term care needs while:
  - giving incentives for risk-pooling;
  - encouraging affordable, reasonably priced and meaningful protection; and
  - providing adequate consumer information and protection.
- Contain state and federal long term care (LTC) expenditures:
  - i.e., keep the rate of growth lower than projected.
- Ensure appropriate utilization of resources:
  - encourage family care; and
  - anticipate some increases in service utilization but build in strong controls, such as pre-admission screening and case management, for appropriate care.
- Assure quality of care, and
- Contain the rate of growth of service fees/prices:
  - protecting the client against "unexpected" inflation.

With these policy objectives providing guidance and a standard against which our progress could be gauged, we then turned to the development of a model.

CONNECTICUT'S MODEL

The Connecticut Partnership for Long Term Care (LTC) would encourage individuals to plan for their LTC needs by purchasing LTC insurance protection in an amount commensurate with their assets. Thus an individual with $50,000 in assets might buy $50,000 in insurance protection while another individual with $250,000 in assets might buy $250,000 in insurance protection. If and when an individual exhausts his/her insurance benefits, he or she can apply for Medicaid and each dollar that the insurance policy has paid out in accordance with state policy will be subtracted from the assets the individual still has so that those assets would not be recognized or considered in determining the individual's financial eligibility for public assistance. In other words, insurance payments for LTC services would be considered as equivalent to the spending of assets for the purpose of establishing Medicaid eligibility. Once on Title XIX individuals would be able to keep control of assets up to the amount that insurance paid; income would still have to be applied toward LTC expenses.

TYPES OF POLICIES

From the start there was general agreement that, for equity's sake, not all insurance expenditures should count toward this Medicaid asset exclusion. Over the last months consensus has begun to emerge on the following conditions:

Insurance benefit pay outs can count toward the asset exclusion to the extent they:

- Occur after the individual meets the state's definition of the insured event; and
- Are for services that Medicaid approves or covers for its own beneficiaries; and
- Are for the lower of the actual charge and the amount paid by the insurance company; and
- Are for nursing home care or formal services delivered to beneficiaries in the community as part of an approved care plan. (In the case of home and community-based services, this care plan must be approved by a Connecticut licensed Coordination, Assessment and Monitoring agency.)

Furthermore, to make it easier for the individual to know what insurance expenditures can offer protection of assets in the Medicaid eligibility determination; for the insurer to market approved policies; and for the state to administer the program, the state is preparing to pre-certify policies which meet specified conditions.

Insurance policies can be pre-certified if they:

- Alert the purchaser to the availability of public consumer information/education sources;
- Offer the option of home and community-based services in lieu of nursing home care;
- Offer case management services in all home care packages - i.e., LTC needs determination, comprehensive assessment, care planning (including assistance in securing services), monitoring, and reassessment;
- Offer automatic inflation protection or optional periodic per diem upgrades as long as the beneficiary is not "in benefit"; and
- Keep records of, and provide explanation of benefit reports on insurance payments which count toward Medicaid asset exclusion.

The state will not pre-certify policies which require prior hospital or nursing home stays to trigger benefits.

For the purpose of a demonstration, it might be necessary to limit pre-certification to insurers who are willing to offer comprehensive policies with benefit periods ranging upward from one year; and to gather and share information necessary for the evaluation - including aggregate data on applicants who were turned away.

SIMULATIONS

We then tried to estimate costs and benefits.

Using the national data from the Brookings/ICF model, we simulated the impact of the "Connecticut Partnership for LTC" on public and individual resources and got some encouraging - although preliminary - results. In the period 2016 through 2020:

1. It is estimated that 55.3% of the nation's elderly persons could have LTC insurance. (Criteria for purchase: insurance costs less than 5% of their income and minimum assets of $25,000. This is a tighter affordability test than is usually used so it gives us low estimates of coverage relative to other models.)

2. 25.7% of the nation's nursing home expenditures could be paid by LTC insurance.

3. The percentage of LTC expenditures paid by Medicaid could be reduced in all income groups an aggregate 11.9%, i.e., approximately $5.8 billion if implemented nationwide, with the biggest impact on those individuals with income between $7,500 - $20,000. Specifically:

Family Income	Percent of Bill Paid by Medicaid
$ 7,500 - $15,000:	from 57% to 49% or a 14% reduction
$15,000 - $20,000:	from 36% to 30% or a 17% reduction

4. The percentage of LTC expenditures paid out of pocket (from income and assets) would drop while the percentage paid by insurance would increase, particularly for higher income groups.

5. The rate of increase in Medicaid outlays for LTC would be slower under this model than otherwise projected.

We are currently working to refine these simulations using Connecticut-specific data - including the unique information we have been able to obtain on true length of stay and length of private and public coverage by matching eight years of nursing home patient records with Medicaid files[1].

MERITS

In our view, the Connecticut Partnership for Long Term Care has several merits. It:

- Provides individuals with a way to prevent impoverishment;
- Gives individuals an incentive to buy insurance;
- Extends means-sensitive assistance;
  - The rich will never automatically get publicly-financed care as in some proposals currently before the congress.
  - Those who qualify for the public program via insurance will have assets they would have otherwise exhausted. (Medicaid eligibility will not start any earlier than it would have in the absence of insurance.)
  - Persons of limited means will find insurance more affordable because they would be able to purchase lower amounts of asset protection.

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[1] See "Data Set the Stage for Policy Decisions", Business and Health, August 1988.

- Stimulates private insurers to develop products for a wider market - for the poor as well as the rich;
- Appears to save federal and state Medicaid funds; and
- Influences the types of coverage offered under private long term care insurance. Pre-certification would only be available to policies which offer comprehensive care while discouraging inappropriate utilization.

LEGISLATIVE PROPOSAL

If we are to demonstrate and evaluate this model, federal legislation appears necessary. Such legislation should:

1. Provide the mandate for a HCFA demonstration - including up to eight states - to test the cost-effectiveness of public/private models.
2. Authorize these states to amend their Medicaid regulations to specifically allow the state to disregard assets equal to approved long term care insurance expenditures.
3. Provide lasting assurance that anyone who purchases LTC insurance during the demonstration will be able to protect assets equal to approved long term care insurance payments if and when they need Medicaid assistance.

CONCLUSION

Long term care is one of the most complex and important issues facing our state and our nation. The Robert Wood Johnson grants are providing vital information on ways and means to deliver and finance needed care. I appreciate the chance to appear before you today and welcome the opportunity to answer any questions about our model or our need for federal legislation.

Chairman **Stark**. Mr. Berman.

STATEMENT OF HOWARD BERMAN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, THE BLUE CROSS AND BLUE SHIELD ASSOCIATION OF THE ROCHESTER AREA AND THE FINGER LAKES LONG-TERM CARE INSURANCE CO.

Mr. **Berman**. I am Howard Berman, president of Blue Cross and Blue Shield of the Rochester Area.

Others have already had the opportunity to appear before you on behalf of the entire Blue Cross and Blue Shield system. I am here today as the representative of one Blue Cross and Blue Shield Plan—a plan, however, which has learned firsthand the difficulties as well as the importance of bringing affordable long-term care benefits to our community.

I appreciate the privilege of being able to appear before you today. I have submitted a formal statement. Therefore, I will not use this brief time to repeat it.

I do not come here with either a quantitative model or a universal program. The baggage I carry is simply that of passion. No one who has been in a nursing home, a retirement center, or the residence of any person struggling to maintain their independence and self-esteem can talk about long-term care without passion. My passion, however, is tempered by the pragmatic force of the marketplace and the loneliness of taking what is, at the moment, the path less traveled.

It is now almost a year since we introduced our first long-term care insurance product. In the next few months we will bring to the marketplace a number of new products, each a descendant of the first and all reflecting the lessons of the first.

The long-term care policy which we developed in Rochester, NY, is different from others in the nation. We began with a product aimed at individuals and which provides, without prior institutionalization, a comprehensive service benefit of home care, adult day care, respite care, nursing home care, and a case manager to serve as the beneficiary's ombudsman.

We protected against the threat of inflation by making it a service benefit: a guaranteed amount of care, not a guaranteed amount of dollars. We also provided that the renewability of coverage be assured.

We have learned since first introducing this product that we must have both a group and an individual product. The group product must also allow for the coverage of not only the employee but also the employee's spouse and everyone's parents.

We also learned the importance of psychological as well as financial independence. The need and value of service benefits for home care and adult day care has been reinforced by the marketplace. People want to remain in their homes for as long as they can. They want to be left with more than just opinions and old memories.

Like everyone else, we also learned that as a nation we have a problem, a problem which will personally affect almost all of us in the years ahead. We will be affected either as persons needing and using long-term care services or as the children of those persons.

Long-term care financing is a problem, however, which begs for not only a flexible solution, but also a solution grounded in a public/private sector partnership.

At this point, it also requires a measured response. We should recognize that in perhaps as little as 10 or 15 years the nature of the problem will have changed from the current circumstances of ill-preparedness to one wherein many people will have had the means and opportunity to plan for these expenses, just as they now plan for their retirement.

Certification and tough standards are an important step in this overall process. The need for standards to protect consumers who purchase long-term care insurance is unarguable.

The debate, therefore, should not be around need. We are past that point. What we should be discussing is how far standards should reach. I believe that it is vital even at this early stage that we do more in setting standards.

Standards should, for example, recognize the importance of maintaining people in their homes by including home care and adult day care benefit requirements. They should also prohibit waiting periods for home care and adult day care, and require patient advocate programs—that is, programs which will guide beneficiaries through the long-term care maze to assure they receive proper services. Standards should also include a provision to insure that inflation protection is provided.

In the same vein, we must also go further on the other side of the equation. If certification is to be more than a damage prevention measure, it must be linked to positive incentives.

For example, linking the holding of a certified long-term care insurance policy to the waiver of the medicaid spend-down provisions provides a powerful incentive both for people to buy these policies and for insurers to have their policies certified.

Clarifying that individual and employer contributions toward certified long-term care insurance premiums are tax deductible would also provide an important impetus to the increased purchase of long-term care insurance.

Obviously, even these steps are only a part of the answer. They are, however, an important beginning.

If there are any questions, I would be pleased to answer them.

Thank you.

[The statement of Mr. Berman follows:]

TESTIMONY

OF

BLUE CROSS AND BLUE SHIELD OF THE ROCHESTER AREA

AND THE

FINGER LAKES LONG TERM CARE INSURANCE COMPANY

LONG-TERM CARE INSURANCE

BEFORE THE

SUBCOMMITTEE ON HEALTH

COMMITTEE ON WAYS AND MEANS

UNITED STATES HOUSE OF REPRESENTATIVES

BY
HOWARD BERMAN
PRESIDENT AND CHIEF EXECUTIVE OFFICER

SEPTEMBER 26, 1988

Thank you for the opportunity to submit a statement on a topic as important as long-term care.

My name is Howard Berman. I am the president and chief executive officer of Blue Cross and Blue Shield of the Rochester area and its subsidiary, the Finger Lakes Long Term Care Insurance Company.

For more than 50 years, our corporations have been providing health-care coverage for residents in and around Rochester, New York. In keeping pace with consumer needs and our tradition of innovation, we introduced our first long-term care insurance policy in late 1987.

In my testimony, I will discuss H.R. 5085 -- which calls for establishing standards for certifying long-term care insurance policies. I also will review additional standards that should be added to the National Association of Insurance Commissioners' model act and regulations; additional incentives to encourage groups and individuals to purchase policies; and other possible actions Congress can take to facilitate the development and sale of long-term care policies. My testimony concludes with a summary of Blue Cross and Blue Shield of the Rochester area's activity on selling long-term care insurance.

H.R. 5085 -- the Long Term Care Insurance Standards Act of 1988 -- is important to the process of discussing the establishment of standards of quality for consumer protection in the purchase of long-term care insurance policies. As you know from previous testimony, the Blue Cross and Blue Shield Association and its member plans have been actively involved in the development of the NAIC long-term care model act and regulations.

The model act, however, does not offer enough guidance to the States. In particular, we support the additional standards in H.R. 5085 including:

- Coverage for care in all settings - Policies should be required to cover custodial care in all settings in which it is currently provided. These include: state licensed nursing homes, hospitals, hospices, adult day health care centers, and non-institutional residences. This would allow for responsiveness to patient preferences, as well as maximum flexibility and cost effectiveness in the development of long-term care service plans.

- No eligibility restrictions -- Policies should not limit, restrict or otherwise condition eligibility for benefits to those who have been institutionalized. In addition, policies should not limit, restrict, or otherwise condition eligibility for benefits in a nursing home or home care to those who have previously received a higher level of services.

- Providing policyholder with policy description - At the time a policy is issued, insurers should provide descriptions of levels of coverage; daily or per visit payment rates; length of coverage provided; maximum amounts payable; policy limitations; any inflation enhancers; and conditions under which the policy may be cancelled.

While we support the provisions in H.R. 5085 that go beyond the NAIC standards for long-term care policies, we recommend that these provisions be expanded further to include additional requirements. These include:

- Policy exclusions - Qualified long-term care insurance policies should not be permitted to exclude coverage for such conditions as Alzheimer's disease.

- Respite care - The policy should provide coverage of "Respite Care," so that family caregivers can have up to 14 days of time off each year.

- No waiting periods for certain benefits - Policies should not contain waiting periods for coverage of home care or adult day health care centers. First-day coverage for these benefits should be available.

- Patient advocates - Expert guidance is needed so that the patient, family and physician work together to develop a plan of long-term care services that takes into account all available resources to meet a patient's individual health care needs. Through case management, the patient advocate can monitor the appropriateness of care plans and ensure that the needs of the individual are continuously met. All "certified" policies should incorporate this type of beneficiary support.

- Minimum coverage levels - To be certified, policies should have minimum coverage levels that are equal to an established percentage of costs of services.

- Inflation enhancers - Certified policies should be notably classified into two categories; those that have inflation enhancers, and those that do not. This would allow consumers to evaluate more easily the policies that suit their needs.

These added features are important to the real value of the insurance and to address the expressed needs of the elderly.

In addition, we believe that any legislation passed by Congress should not require the following:

- Annual review - Policies that have met the established requirements for certification should not have to be reviewed each year to retain this status. Annual reviews are costly and an inefficient utilization of resources.

- Review of advertising - Advertisements for certified policies should not be required to be reviewed and approved by the State commissioner or superintendent of insurance. These reviews are unnecessary and costly.

The importance in establishing standards lies in its ability to awaken the public to the need for such coverage. However, we support other incentives to encourage consumers to plan for their long-term care needs.

TAX INCENTIVES FOR THE PURCHASE OF LONG-TERM CARE INSURANCE

To successfully motivate consumers to purchase policies, certain tax incentives are needed for individuals, insurers and employers.

For individuals, legislation should be passed allowing the purchase of long-term care insurance with pre-tax dollars through flexible spending accounts under Section 125 of the Internal Revenue Code.

For insurers, the government should permit certified long-term care liabilities to be treated on a tax-favored basis. Reserves should be calculated using the "one-year full preliminary term" methodology instead of the current two-year requirement. Under current law, insurers cannot establish tax-favored status for the reserves of most types of health insurance until the policy has been in force for two years. Allowing tax-free reserve build-up after one year would help insurers keep premiums as low as possible.

For employers, the bill should clarify that employer contributions toward long-term care insurance premiums are a deduction from current operating expenses.

FACILITATIVE ACTIONS

Congressional action in the following areas may also facilitate the private sector development of long-term care insurance. We believe that proposals to waive the Medicaid spend-down requirement for individuals who purchase long-term care products should be closely reviewed as a way of encouraging people to plan for their long-term care needs.

In addition, provisions for the collection of long-term care data should be incorporated into any federal legislation addressing long-term care. Data regarding long-term care utilization patterns are essential to actuaries rating long-term care policies as well as to health care professionals developing long-term care service programs. To establish a national database, we recommend the merging of files from Medicare, state Medicaid programs, the National Center for Health Statistics, and the National Home Care Association, among others.

Pooling statistics allows private insurers to better predict their liabilities; this, in turn, should lead to more affordable long-term care insurance.

SUMMARY OF BLUE CROSS AND BLUE SHIELD OF THE ROCHESTER AREA'S ACTIVITIES

In 1985, we began to develop solutions to many of these significant long-term care financing issues. We have worked with the New York State Insurance Department, the national Blue Cross and Blue Shield Association, and a myriad of state, county and local organizations in bringing our product to the public. Recognized as one of the pioneers in the long-term care field, we serve as a resource to organizations around the country.

The long-term care policy we developed in Rochester, N.Y. is different from any other available in the nation.

The Blue Cross and Blue Shield of the Rochester area policy covers custodial care -- the service that is in greatest demand and which is not covered by acute care programs such as Medicare. Coverage is provided in a wide range of settings -- adult day health care centers, nursing homes and, most importantly, in the home. Entitlement is based on an evaluation of cognitive and behavioral impairments, as well as activities of daily living. Importantly, custodial care, regardless of its level of intensity, even if in a skilled nursing facility, is covered.

The policy offers direct admissions to the care settings. In other words, no prior hospitalization is required for a nursing home stay and no prior nursing home stay is required for home care or adult day health care.

The program provides trained professionals to work with the individual and their families in developing an appropriate plan of care. These patient advocates help make arrangements for obtaining needed services. With their extensive health-care backgrounds, these advocates can identify alternatives to nursing home care. They can help the policyholder remain at home in familiar surroundings when that plan of care is adequate.

A unique benefit of the policy is its coverage of "Respite Care." This provides family members who are the primary caregivers with 14 days of time off each year.

Additionally, the policy allows for retirement planning through its variable payment terms, including 10-year and 20-year paid up options.

Protection against inflation is provided automatically. Blue Cross and Blue Shield of Rochester area pays 75 percent of the cost of services -- not a fixed dollar amount. People have asked us: "What about the 25 percent policyholder copayment?" Out estimates indicate that 25 percent copayment can be paid by using the Social Security benefit which an individual receives. Thus, the person's assets will be left, for the most part, intact.

To qualify for the policy, a person must be in reasonably good health for their age. Applicants must pass a medical screening to be accepted. Once an applicant has been approved and has purchased the policy, their long-term custodial care needs are guaranteed. We do not exclude coverage for specific medical conditions, such as Alzheimer's disease.

That is a description of our policy and how it provides for the long-term care needs of the elderly.

We believe we have developed a long-term care policy that addresses several of the major concerns of the elderly: it provides coverage for care, which might otherwise impoverish them; it provides assistance in obtaining care, so they aren't faced with making these important decisions alone; and it provides coverage for alternatives to nursing home care, eliminating their concern of having to leave the familiar surrounding of their home.

While introducing such an innovative long-term care program is very gratifying, we are not resting on what we have done. We are now in the process of developing group long-term care insurance with local employers. In addition, a second generation of long-term care products have come off the drawing board and are going through final preparation for filing with the New York State Insurance Department.

We acknowledge that no one has all the solutions to the financing of long-term care. Questions remain ... such as dealing with those currently ill and determining whether they can be grandfathered into new benefit packages. We applaud the committee's efforts to develop long-term care legislation. Your actions not only represent thoughtful and realistic progress on this issue, but they also set the stage for continuing discussion on how the public sector and private sector can forge ahead in a partnership to:

- Educate concerned individuals to the needs of the elderly ... the frail elderly as well as the sick.

Unfortunately, the public perceives that Medicare and the recent catastrophic legislation offers long-term care protection; this misunderstanding must be corrected.

- Provide a source of insurance for the cost of long-term health care.
- Develop/implement methods to finance prolonged care.

We must be flexible, innovative and responsive to a constantly changing long-term care environment. It is with this understanding that we support what you have done and call upon others to join you and us in settling this frontier in financing of health care services.

Thank you.

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Chairman **Stark**. I have just a couple of questions.

Mr. Berman, you mentioned in your testimony—I can't find it right now—a 10-pay and 20-pay model, paid up.

Mr. **Berman**. Correct.

Chairman **Stark**. Can you off the top of your hat describe one of those? Give me a premium and age. Can you think of a for instance? For instance, at age 55 or 50, what would a policy cost and what would it provide?

Mr. **Berman**. What we have tried to do is provide the opportunity to link planning for retirement or long-term care expenses. If you were to pay a 10-year paid-in-full policy at age 55, at age 65 you would have all your long-term care expenses covered under that policy.

The benefits are the same as under the annual pay policies. The premium differential is about $138 for the 10-year paid-up versus about $85 for the annual.

Chairman **Stark**. $138 a month?

Mr. **Berman**. Yes.

Chairman **Stark**. So if you paid $138 a month, at age 65, what do you estimate your benefits to be if your worst fears hit you 10 years later?

Mr. **Berman**. You would have at a minimum 3 years of nursing home care regardless of the level; you would have that exchangeable for home care or adult day care on the basis of two for one, so that translates to 6 years of home care as an alternative. You have 14 days of respite care for the family. You would have the patient care manager.

Chairman **Stark**. That is three years at 100 percent?

Mr. **Berman**. At 75 percent.

Chairman **Stark**. So is a fair price in Rochester $24,000?

Mr. **Berman**. Yes.

Chairman **Stark**. So it would pay——

Mr. **Berman**. Roughly $18,000.

Chairman **Stark**. Eighteen to $24,000 a year is effectively a maximum pay-out?

Mr. **Berman**. Correct.

Chairman **Stark**. Now, I also noticed in your testimony you talk about reasonably healthy. I think you say you have to take a medical example, if I recall your testimony. But I have been led to believe that something like—I am going to say 80 percent, but maybe it is two thirds of people who require long-term assistance or care, nursing home care, may not need medical assistance.

So my question is, either your experience is showing something different or you are just very worried about adverse selection as you get started. You couldn't tell that 80 percent of the people are going to need long-term care from a medical example, why are you doing it? I guess that is the question.

Mr. **Berman**. We are doing it simply because we can't control who will apply and we wanted to make sure that people who were currently in nursing homes, for example, did not apply.

Chairman **Stark**. Or who had Alzheimer's or who had a disease you knew was going to lead immediately to institutionalization—I am not criticizing.

Mr. **Berman**. Alzheimer's is a difficult and tough call because clinically you can't diagnose it until autopsy, and that is not part of our medical underwriting process. So we may have Alzheimer's patients, but we don't know it.

Chairman **Stark**. Mr. Mahoney, someplace in your testimony you suggest that—I am not sure you meant to suggest it, but I am reading it to say the richer you are, the more we protect your assets from decimation, because the richer you are, the more of this insurance you buy—$50,000 to $200,000. I am not sure that is fair, but to put it another way, shouldn't the very lowest income people who still may have a house, may have a modest equity, shouldn't there be a kind of floor to say if you are going to protect assets for people who can buy $250,000 of insurance, there should be minimum protection for the lower-income folks?

Mr. **Mahoney**. That perhaps is a misunderstanding. Our approach would call for, it would encourage people to buy a private insurance they could afford. If I only had $20,000 or $30,000 in assets, maybe all I could afford is a one-year policy. Here is where the public part of the partnership comes in. If I ever exhausted my insurance, the Medicaid program could then step in and provide continued coverage, and I would be able to protect the $15,000 or $20,000 that previously I would have had to exhaust—impoverishing myself.

The wealthier person could perhaps afford a lot more coverage, but it would be very rare they would ever exhaust it and apply for Medicaid. But, as I say, we envision offering the same incentive to middle and upper income persons if they ever did exhaust their long-term care insurance. The amount of insurance paid out could be subtracted from their assets as well. Still, if they are millionnaires, they would never go on to Medicaid.

Chairman **Stark**. Could I get a comparable—because I have to go back and think about this myself—for somebody at age 55—I don't know what is comparable to Mr. Berman's $18,000 a year for 3 years at some indeterminate date in the future. I can't do that with my shoes and socks on.

Can you give me an idea what $50,000 or $100,000 of your Connecticut model insurance would cost at age 55? Is there a paid-up amount or do you have to pay for life?

Mr. **Mahoney**. We are not offering a product, but for the simulations we have been able to do and through the Robert Wood Johnson Program we have had access to the model that the Brookings ICF people have developed. But to give you a picture—and Dr. Meiners could probably do a better job describing the premium structure—but for someone 65 years old a pretty comprehensive 1-year policy with only a 30-day deductible would cost something in the low $400 per year, whereas if I were the wealthier person who could afford a 3-year policy, the premiums estimates were somewhere in the $980 or $970 range.

So this gives you a picture.

Chairman **Stark**. That would give you 1 year of nursing home care?

Mr. **Mahoney**. Right.

Chairman **Stark**. I have apples and oranges here. Mr. Berman and I have a couple of quotes from my favorite insurance salesman:

$85 a month if I want to pay forever, for which at any point I presume after I am 65 I could get up to 3 years, 75 percent coverage, which now we will say is $18,000 a year for 3 years indexed because it is part of coverage.

I have an asset protection thing which I have to go back and try to translate later. But I am trying to figure out, if I have $1,200 I am going to pay $1,000 under his forever policy, which means I have $25,000. I don't have to have that much in assets to buy yours.

To protect $50,000 in assets, what would I have to have?

Mr. MAHONEY. Mr. Berman whispered to me that our 3-year policy is roughly like the one he was talking about.

Chairman STARK. I was wondering what it would cost at age 55. I suppose at 65 it would be a lot different.

Mr. BERMAN. The only number I walk around with is the 65 number. The 85 a month is annual lifetime at 65. The 138 is less recollection of 10-year at age 55.

Chairman STARK. That is a month. You are saying for 3-year coverage it would be about $980?

Mr. BERMAN. That is about the same.

Chairman STARK. Now I have to go back and read it. Don't send your brother-in-law to call on me.

Mr. MEINERS. It may be helpful to give you a little history as to where this asset protection strategy came from.

The notion, when it was first talked about was giving asset protection after 3 years if somebody bought a 3-year policy. The concern was that there would be some people who could not afford a 3-year policy. If you structured a public program in that way, it would be mostly for higher income people.

The current approach is geared to use that same basic strategy but to make it more flexible. A person who has lower assets to protect probably also has lower income to afford a policy, too. So there is a more of a direct link between what people can afford and what they may want to protect.

Certainly a person with a higher income could buy a lower benefit policy and expect to pay out of pocket for a period of time up to the level of protecting the policy—however, we expect there is a linkage between the affordability and the amount of protection a person would want to purchase in terms of asset protection. So that is part of the structure that has been established.

You mentioned the house. You are right, many elderly own their own homes, but currently under the Medicaid program the house is protected pretty well. There may be a whole other discussion as to whether we ought to think about the role of protecting the home, but the chief asset is quite well protected under the Medicaid program as currently administered.

Chairman STARK. There are no reserves in your policy, Mr. Berman; I mean if you die in an auto accident, you don't have any cash value in your paid-up 10 years or permanent policy?

Mr. BERMAN. Not at this point.

Chairman STARK. Have you sold a lot of them?

Mr. BERMAN. No.

Chairman STARK. So you don't have enough experience.

Mr. **Berman**. No, we don't. As a matter of fact, we have tried to sell it at the higher age spectrum so we can get some experience administering the benefit. We would love some experience.

Chairman **Stark**. Did you use the same model that they are using in Connecticut?

Mr. **Berman**. No.

Chairman **Stark**. You are putting away $25,000—I don't know what it comes to with interest—if they don't collect for 10 years. So a person is out of pocket $17,000 over the period, and if you don't have any experience I just don't know what that would equate to in terms of broader coverage, but we will look at it.

We appreciate your willingness to help us as we ponder through what our role in this partnership ought to be. Thank you very much.

The committee will recess.

[Whereupon, at 4:05 p.m., the hearing was adjourned.]

[Submissions for the record follows:]

HOUSE SUBCOMMITTEE ON HEALTH
OF THE COMMITTEE ON WAYS AND MEANS
HEARINGS ON LONG-TERM CARE

STATEMENT FOR THE HEARING RECORD
BY THE
COMMITTEE ON HEALTH
AMERICAN ACADEMY OF ACTUARIES
ROBERT H. DOBSON, CHAIRPERSON

AUGUST 12, 1988

The American Academy of Actuaries is a professional association representing actuaries in all areas of actuarial practice. Members of the Committee on Health who prepared this testimony are employed both as consultants and by insurance companies. For purposes of this testimony, however, we speak as professional actuaries and not on behalf of our clients or employers. The Academy and its committees do not advocate public policy positions that are not actuarial in nature. We view our role in the government relations arena as providing information and actuarial analysis to public policy decision makers, so that policy decisions can be made on the basis of informed judgment.

As a professional association, the Academy neither supports nor opposes legislation to provide for the public financing of long-term care. We do, however, believe the cost of providing such benefits has been understated. As the dialogue begins on the delivery and financing of long-term care, we want to provide policymakers with the best information on this complex topic. It is very difficult to make cost projections for long-term care; however, we believe that the training and experience of actuaries provides for a unique understanding of current practices in the financing of health care, and we hope to contribute to the examination of this issue.

The following comments discuss issues relating to long-term care in general and focus specifically on the Long-Term Care Assistance Act of 1988, S. 2305, proposed by Senator George Mitchell.

I. COST ISSUES

A. Demographic Issues - Increasing Cost as the Population Ages

The chart below outlines the projected increase of the population over age sixty-five.

	------Population in Millions*------					
Year	(1) Total All ages	(2) Age 65+	(3) Age 65-74	(4) Age 75-84	(5) Age 85+	% of (2)/(1)
1980	226.5	25.5	15.6	7.7	2.2	11.3%
1990	249.7	31.7	18.0	10.4	3.3	12.7%
2000	268.0	34.9	17.7	12.3	4.9	13.0%
2010	283.2	39.2	20.3	12.3	6.6	13.8%

The U.S. aged population has increased and is projected to increase dramatically from an actual 25.5 million in 1980 to a projected 39.2 million in the year 2010. This is a projected increase of over 50%. However, the number of age eighty-five and over (85+) will triple in the same thirty years, from 2.2 million to 6.6 million. Currently, 13.4% of those aged sixty-five and over (65+) cannot perform at least two or more activities of daily living (ADL). The comparable percentage for those aged 85+ is 36.1%.

Additionally, a conservative estimate is made that a minimum of 5% of those 65+ suffer from dementia, but are able to perform all the ADLs or all but one ADL. Given these projections, the need for, and expenditures on, long-term care (LTC) is likely to increase dramatically in the ensuing years, particularly for the 85+ group.

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*Source is "Aging America - Trends and Projections" 1987-88 Edition.

B. Induced Demand - Entitlement Mentality and Increased Supply - Health Industry Response

Once chronic home care benefits are provided through the public or private sector, the mentality of the consumer will likely be to liberally use these benefits. The independent assessors from the eligibility review organizations may have a very difficult time denying many possible borderline cases regarding the criteria of inability to perform at least two ADLs and as to when respite care is really "necessary." Induced utilization of the nursing care benefit may be less severe, particularly because of the two-year exclusionary period. The insurance industry will likely develop policies to fill this gap in coverage.

Since home health agencies are likely to be the primary providers of the chronic home health care benefit, we believe that these agencies will multiply quickly to satisfy the demands of the possible millions of new beneficiaries. Again, the insurance industry will enhance this movement with policies to fill the gap.

We must emphasize the likelihood of cost increases as a result of induced utilization under a program providing long-term care insurance. We strongly believe that costs will increase beyond the increased number of beneficiaries and inflation as a direct result of the additional financing.

The attached table illustrates the utilization history of an existing program (Medicare's home health care program) for a population likely to use the benefits that would be provided under S. 2305. We believe the induced utilization effects caused by influences such as those listed in Column 4 account for a substantial proportion of the patterns of use illustrated. An absolute quantification of what proportion of the trend changes are due to induced utilization cannot be precisely made or proved. However, in "real world" casting, strong circumstantial evidence presents itself in characteristic patterns (e.g., the relatively violent utilization swings in a program of this size).

Our concern regarding induced utilization is further supported by data as to the proportion of the over-sixty-five population currently in nursing homes versus the proportion with limitations on activities of daily living. Data from the U.S. Bureau of the Census (Demographic and Socioeconomic Aspects of Aging in the United States) show that 5.1% of the over-sixty-five population are in nursing homes, while an additional 6.9% have limitations on activities of daily living (ADL). An Inquiry magazine article in 1980 cited the total proportion of the over-sixty-five population with major ADL limitations as 17%. Since many of these individuals could seek nursing home care if financial obstacles were reduced, we believe that additional public financing of long-term care could conceivably double or triple the total proportion of the over-sixty-five population in nursing homes.

We are not suggesting that S.2305 would lead to a greater degree of induced utilization any more than any other public or private financing of long-term care. What we wish to emphasize is that policy makers must be aware that costs will increase because of additional financing and that this must be kept in mind as the issue of long-term care is debated.

C. Eligibility for Benefits

The provision of home health care benefits (80% payment by Medicare after a $500 per year home care expense) for the aged with chronic illness who cannot perform at least two of the ADL without human assistance, or who have dementia, opens the door for about 5.5 million aged 65+ persons. In addition, a considerable portion of the approximately 4 million (under sixty-five) Social Security disability insurance beneficiaries might be eligible for this benefit. Thus, more than 7 million persons might be eligible, even now for this benefit, for which no cost estimate has been given in S.2305. The only restriction given is that home health care costs cannot exceed 65% of skilled nursing facility (SNF) Medicare nursing home costs. Assuming that an average SNF cost per day is currently $70 to $100, the 65% limitation stipulated would create an average current daily liability of $45 to $65. Currently, approximately 80% of these persons are receiving home care only from a spouse or relative.

A respite care benefit provided in this bill would provide a $1,000 annual benefit ($2,000 of charges at 50% co-payment), for at least the 80% of those persons above who are now getting informal care.

The eligibility requirements for the above benefits may be difficult to assess correctly and consistently, due to the subjectivity of the ADL performance determination, without any homebound or other screening requirement. With a two-year exclusionary period for the nursing home benefit, we cannot foresee large-scale difficulties in making equitable eligibility determinations.

D. Cost Estimates

There are no cost estimates given in this bill. Instead, the claim is made that the program will remain budget neutral. We question that a useful government LTC program can be established that will be budget neutral without imposing an inappropriate burden on the elderly. Adding homemaker and chore services, as well as serving significantly more beneficiaries (see Eligibility for Benefits section) will be very expensive. Removing the homebound and intermittent service requirements will further add to the cost. This will also be a growing cost in the future, not only due to inflation, but also due to the increase in exposure (see Demographic Issues). Changes in demand and supply will also affect cost (see Induced Demand). All of these factors make it difficult to estimate costs.

Based on Congressional Budget Office estimates, the nursing home cost in FY 1993 with a two-year exclusionary period, will approximate $1[illegible].2 billion. Our own very rough estimate for the 7 million extra beneficiaries [illegible] home health care might range from $22 to $34 billion for the first year a[illegible]n additional $3 billion for respite care. In claiming budget neutrality, S.2305 would do all this by adding a fixed and income-based premium to the current Medicare Part B premium.

E. National Affordability or Medicare Eligible's Burden

One of the most problematic aspects of this bill is the enormous and spiraling burden placed on Medicare beneficiaries for the privilege of participating in the program. First, all Part B beneficiaries will see increases in their basic premium. However, political reality may not allow this increase to become too extreme. As program costs increase, the only "moving target," the supplemental premium, will impose a significant and unpredictable "tax" burden on those (44% - according to catastrophic bill estimates)* who will have to shoulder the experiences of the whole group.

The combination of the Medicare catastrophic legislation and the Mitchell bill could add up to a significant amount in supplemental premiums in a few years. Some of these individuals may not have enough left over to pay premiums for Medicare supplemental or LTC insurance to fill the gaps. If this bill is enacted, the cost of medical care ($44 to $57 billion extra) will certainly increase as a portion of the GNP from its present 10%-11%, since a large percentage of these costs were previously absorbed by family support. When the tax burden on Medicare eligibles gets too high, who will be handed the tax baton to pay the ever-increasing costs of this LTC program?

II. POLICY DECISION - NURSING HOME CARE VS. HOME HEALTH CARE VS. FAMILY SUPPORT

As long as quality of health and personal care is maintained, home health care should be favored over nursing home care. Costs will be less, not only because of the 65% of SNF maximum allowable for home health care, but also because professional nursing/chronic care services might not be required on a daily basis, particularly if family support is available. In fact, the purpose of respite care is to allow some relief to persons providing family support. In essence, however, the bill will encourage substitution of professional home health care for family care.

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*Appropriate only only if S.2305 income-scaled premium is equal to catastrophic Medicare income-scaled premium.

III. PRIVATE SECTOR INITIATIVES

Some fifty to seventy commercial health insurance carriers, in addition to sixteen Blue Cross and Blue Shield Plans, currently have a long-term care policy on the market. The policies vary in benefit scope and level, but are primarily indemnity in nature. This implies significant cost-sharing and limited insurer liability.

Senator Mitchell's bill will affect many private-sector policies by reducing the benefits they are providing to a "fill" level. However, since there is a $500 deductible on home health care with a 20% co-payment after the deductible, and a two-year exclusionary period on nursing home care with a 30% co-payment, there is considerable room for new private-sector policies to fill these gaps.

IV. DESIGN ISSUES

One recognized shortcoming of the bill, as well as with virtually all current private-sector policies, is that the insured is still exposed to a significant LTC financial risk. Since this bill has a two-year exclusionary period on nursing home care, a person could become impoverished by that time. Likewise, the 30% co-payment on nursing home care after year two, and the 20% co-payment on home health care, could add up very quickly to greatly increase the individual's expenses. The private market indemnity program usually has an elimination period of twenty to 100 days, a significant co-payment after the elimination period, with a two-to-four year benefit maximum, or an equivalent dollar maximum limitation. The accumulation of co-payments and subsequent full payments by the individual after exceeding the insurer's upper limit of liability also does not protect the individual from a financial catastrophe. Since, however, cost is a major concern, legislation such as this is a good starting point. We believe the public/private approach is certainly worthy of further discussion and development.

V. CONCLUSION

The purpose of this statement has been to point out cost issues, policy decisions, and the private sector response relating to this legislation. We hope that as Congress continues further on the development a new Medicare benefit for long-term care it will proceed with caution and deliberation, bearing in mind the concerns we have raised. We would be happy to meet with the Committee or members of the staff to further discuss these issues.

Attachment

Induced utilization of professional medical care for the elderly, prompted by:

- long term establishment of an insurance program,
- expanded contractural insurance benefits,
- changes in administratively defined benefits/medical necessity standards.

The long-term history of the Medicare home health care program displays the following:

(1) Calendar Year	(2) Home Health Care Visits Per 1000 Medicare Enrollees*	(3) % Change in (2) From Prior Year	(4) Significant Events Affecting Utilization: Comments
1969	427		Initial coverage "utilization bulge" and aftereffects (including, probably, administrative tightening).
1970	291	(31.9%)	
1971	226	(22.3%)	
1972	241	6.6%	
1973	265	10.0%	Disabled and ESRD beneficiaries eligible for Medicare, 7/1/73.
1974	340	28.3%	
1975	431	26.8%	
1976	520	20.6%	Era of loosening/lax administrative/medical necessity standards, probably.
1977	597	14.8%	
1978	639	7.0%	
1979	717	12.2%	
1980	792	10.5%	
1981	902	13.9%	Elimination of prior hospitalization/SNF requirement and 100 annual visit maximum - 7/1/81.
1982	1,060	17.5%	
1983	1,252	18.1%	Final regulations issued 4/5/83 to the Omnibus Reconciliation Act of 1981, to be effective 5/5/83. These regulations make Medicare secondary to employer group health plans for rendered to ESRD beneficiaries within months 3 through 12 after ESRD eligibility is established.
1984	1,343	7.3%	
1985	1,329	(1.0%)	Era of tightened administrative standards; e.g., number of skilled nurse home health visits administratively limited to no more than "two to three weeks" for up to five visits per week, barring certification of extenuating medical circumstances.
1986	1,303	(1.6%)	
1987 (estimated)	1,306	0.2%	
1988 (projected)	1,310	0.3%	

* Source: HCFA/Bureau of Data Management & Statistics

STATEMENT OF GERALD K. DOLAN, PRESIDENT AMERICAN ASSOCIATION FOR RESPIRATORY CARE

As President of the American Association for Respiratory Care (AARC), a 27,000 member professional association, I welcome the opportunity to submit written testimony on the issue of long-term care for the elderly and disabled Medicare beneficiaries. We commend Congress and Chairman Stark for addressing this complex issue.

Respiratory care personnel are employed under medical supervision in treatment, management, control, life support, diagnostic evaluation, and care of patients with deficiencies and abnormalities of the cardiopulmonary system. In hospitals, respiratory care personnel specifically oversee the therapeutic use of medical gases and the administration of aerosolized medications; ventilatory support; bronchopulmonary drainage and exercises; pulmonary rehabilitation; maintenance of natural and artificial airways; and other related duties.

We believe it is imperative that, as Congress deliberates on a structure and form for Medicare long-term benefits, it weigh the increasing amount of care required by the growing number of respiratory patients with the limited role of the Respiratory Care Practitioner in the alternate care setting. The focus of this testimony is on the patient suffering from severe respiratory illness, in particular the mechanical ventilator-dependent individual. We want to emphasize that we are not seeking coverage for direct billing of services for the Respiratory Care Practitioner. We seek consideration for the coverage of respiratory care services delivered by qualified, trained professionals:

- as a benefit through a certified home health agency.
- as a covered service through the Part B DME benefit.

Coverage for respiratory care benefits should be only for those individuals who have been determined to be medically eligible by a case manager. Covering the respiratory care professional component under the DME benefit will not only assist the at-home beneficiary in need of respiratory care, but will also close the coverage gap for Skilled Nursing Facility (SNF) patients. Respiratory care services are covered under the Part A SNF benefit. When Part A benefits are exhausted, the coverage of respiratory care professional services also ends, whether or not the patient's need has ended. If the SNF patient is eligible to receive Part B benefits, the respiratory life-support equipment may be covered, but not the services of a Respiratory Care Practitioner. This change from Part A to Part B literally happens overnight.

The current home health care and Part B benefits were constructed over fifteen years ago and reflected the state-of-the-art medical practices at that time. During those early years, the provision of respiratory care was nearly always delivered in the hospital setting and, most often, in the intensive care unit. Today, the provision of respiratory care has developed far beyond the scope of the iron lung and the oxygen tent. A better medical understanding of a patient's condition and advancement in the treatment regimens, especially in the area of mechanical ventilation, have led to more successful outcomes for the fragile respiratory patient. Many patients with cardiopulmonary lung diseases, who ten years ago could not have left the hospital, can now be routinely stabilized and receive care in a less intensive setting, such as the home or skilled nursing facility. We believe it is not only the financial pressures of the DRG system, but the new non-hospital based treatments available, that have paved the way for treating respiratory patients in alternate sites.

While medical technology in the area of respiratory care has advanced, Medicare alternate site coverage for these respiratory patients has not kept pace with the changing medical environment. The irony of this situation is most strongly illustrated by the ventilator-dependent patient. Many of these patients can be medically stabilized to the point where they no longer require the services of an acute care hospital. There are extreme financial pressures for the hospital to discharge these patients. However, many physicians are reluctant to discharge ventilator patients if the necessary respiratory care is not provided or covered in the alternate setting by qualified respiratory care professionals. Therefore, the patient remains in the hospital. We share Congress' concern over the Federal deficit and the rapidly escalating costs of the Medicare program. However, the cost to the Medicare program in the case of ventilator patients is particularly compelling.

In 1985, the AARC conducted a survey of ventilator patients in thirty-eight states. The average cost of treating ventilator patients in the hospital was over $300,000 per year. To treat the ventilator patient at home was approximately $23,000 a year. However, in those cases where ventilator patients are discharged into the home, it is still left to chance whether the DME dealer or the HHA will provide appropriate, qualified respiratory care services. We would further point out that studies have shown cost savings when respiratory patients suffering from chronic obstructive pulmonary disease (COPD) have been treated at home by Respiratory Care Practitioners. The Department of Health and Human Services funded a three year demonstration project conducted by the South Hills Home Health System Agency, the largest hospital-based home health agency in the country. The demonstration project definitively showed that when home-bound COPD patients received the services of Respiratory Care Practitioners, hospital readmissions declined from 1.28 to .48, and the days of actual hospitalization declined from 18.25 days to 6.09 days. It was estimated that, on an average, $2,625 of hospital costs per patient were saved per year.

In order to document patient shift to the alternate site, the AARC recently conducted surveys of Home Health Agencies (HHA's), Durable Medical Equipment Suppliers (DME's), and Skilled Nursing Facilities (SNF's). We wanted to determine how many of these providers offered respiratory care services to their patients. In all three survey sites, respondents indicated the numbers of respiratory care patients, in particular ventilator-dependent patients, had grown, and furthermore, the respondents also indicated that it was the lack of adequate Medicare reimbursement which prevented them from hiring qualified respiratory care personnel to perform the services.

Respiratory care is more than just the provision of an oxygen tank or oxygen concentrator and the disposable supplies such as cannulas, which accompany the delivery of oxygen. Obviously, there are some respiratory patients whose medical conditions do not warrant the need of a specialized individual with respiratory care training and credentials, but days of having patients with only simple respiratory needs cared for at home are in the past. It is a fact that fragile patients with complex respiratory illnesses are being discharged from the hospital. These patients require the services of a professional caregiver trained and credentialed in respiratory care. The coverage and reimbursement for Respiratory Care Practitioners in the alternate site is limited and, in the case of home health agencies, nonexistent.

It is the AARC's conviction that Medicare should maintain a consistent philosophy on patient care. While in the hospital, respiratory care services including the full services of the respiratory care professional are covered without question. When these patients are discharged from the hospital and the need for respiratory equipment and care persists, it is not logical to provide for the equipment, oxygen, and drugs, but not allow these patients access to the only personnel who are specifically trained to treat the respiratory patient. With the exception of the Comprehensive Outpatient Rehabilitation Facilities (CORF's), Respiratory Care Practitioners are not a covered service.

What, then, is the reality of this medical situation? Our studies indicate that these patients are going into the home. Who, then, is taking care of their specialized needs? Who is making accurate patient medical assessment? Who is monitoring patient outcome and the interaction of the patient with the complex respiratory care equipment? The attending physician makes the initial determination of the medical needs of the patient at hospital discharge. After that, evaluation of the progress of the patiant in the home falls to those who provide the equipment. Patients in need of oxygen and ventilator care are medically assessed by the suppliers of equipment, in many cases a truck driver who makes deliveries for a DME. DME's cannot bill Medicare for the services of the Respiratory Care Practitioner either. No incentive exists to hire the appropriate caregiver. Furthermore, there are no conditions of participation for suppliers of equipment, nor are there required training or educational standards for DME personnel who provide complex respiratory care equipment. DME's, by definition, are a supplier, not a Medicare provider, yet some DME personnel as an everyday practice provide care to patients. There is absolutely no guarantee that when a patient returns home in need of oxygen or ventilatory support that the individual who will provide the setup, education, training, maintenance, and patient assessment will be one who has any training, formal or otherwise in respiratory care.

Home health agencies, as a rule, do not employ Respiratory Care Practitioners because Respiratory Care Practitioner visits to a patient's home are not a covered HHA cost. Again, lack of reimbursement is the cause of compromised patient care. As a result of this situation, most HHA's rely on the suppliers of equipment to assess and monitor the patient's condition, educate the patient or other caregiver, and evaluate the changing respiratory care needs of the patient. The respiratory care patient under the care of an HHA may be faced with care being given by an unqualified equipment delivery person.

The plight of the respiratory care patient will not improve. Indeed, the growth of the aging population and AIDS epidemic will only increase the number of respiratory care patients in the future and their subsequent need for respiratory care support.

The AARC believes Congress should support the coverage of the respiratory care services as a home health benefit and under the Part B DME benefit. We believe that this service should be covered only in conjunction with the implementation of a patient care management system. We are acutely aware of the enormous cost of the Medicare program and the potential problem of overutilization of this benefit. We strongly support the concept of the case manager who would assess the scope of the respiratory care patient's needs. We believe that adding the coverage of the respiratory professional component in a rational way will provide accurate and high quality care for these respiratory care patients.

TESTIMONY OF THE AMERICAN FOUNDATION FOR THE BLIND

The following statement is submitted on behalf of the Trustees and Executive Director of the American Foundation for the Blind. The American Foundation for the Blind, founded in 1921, is a national voluntary research and consultant organization in the field of services to blind and visually impaired persons of all ages.

This statement is presented to add our voice to the growing number of individuals and organizations pointing out the need for a national long-term health care program for all Americans. The need is with us now and it grows greater as the population continues to age; more and more Americans are living past the ages of 75, 85 and even older. As individuals age, one of their greater problems is the loss of sight which, added to other age related disabilities, causes a greater need for care in the home or in a nursing home setting. Long-term care is the help needed to cope, and sometimes to survive, when physical or other disabilities impair one's ability to perform the basic necessities of life.

Estimates vary as to the number of people who are older and blind. A recent study by the National Center for Health Statistics is illustrative. NCHS uses a functional definition to characterize severe vision impairment, defined as the inability to read newspaper print even with glasses. The last NCHS study in 1977 revealed that about 70% of those who were severely visually impaired were over the age of 60, and the total comprised about 990,000 older people.

The latest--1984--NCHS study (National Center for Health Statistics, 1986) which is by far more rigorous suggests that the number of severely visually impaired older citizens is 106% greater than previous estimates, with totals well over 2 million people--roughly the same number of people who experience Alzheimer's disease.[1] This situation is made even more complex because this nation's population is aging so very rapidly. While the impact upon the family is profound, the economic costs are staggering. Available data, for example, suggest that nearly 20% of those who are older and blind reside in long term care institutions.[2]

Four of the five leading causes of blindness are age related, and we must remember that most older blind citizens are people who grew up, worked, reared their families, and most often retired as sighted people. They are simply unable to take advantage of the resources available to younger visually impaired people, and they are unaware of the blindness system and how it works. Because of the increased numbers of older people who are blind, greater demands will be placed upon the family and public institutions as care-givers in the coming decades.

In addition, blindness among the elderly is inextricably involved with other social issues. Older blind people are poorer and more likely to be multiply impaired than the general older population. They are more likely to be women, and they are more likely to be minorities than the general population.[3] Elderly blind living in rural areas have enormous problems with transportation and access to service.

The elderly blind, like others in need of care, would prefer to be cared for at home rather than in an "institutional" type setting. It all comes down to the question of affordable care, both for the individual and for the individual's family. Since the cost of care is so great, and growing as the population ages with more elderly in need of care, the question is how long-term care can be provided, and who pays.

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[1] Nelson, Journal of Visual Impairment, Vol. 81, Statistical Brief 35, 1987.

[2] Kirchner, Journal of Visual Impairment, Vol. 74, Statistical Briefs 11 & 12, 1980.

[3] Kirchner, Journal of Visual Impairment, Vol. 75, Statistical Briefs 13 & 15, 1980.

The American Foundation for the Blind has been a long-time advocate for a National Health Insurance Program, of which long-term care (both at home and in nursing homes) would be a facet. Such a program should be a part of the Medicare system and the costs spread over the entire population . . . not "user" related and not based on need. Such a national program would be the least costly form of providing care. Payment for such a program could come from a removal of the "cap" on income subject to social security/medicare tax, and increased taxes on consumer products such as liquor and tobacco products.

Private insurance cannot provide protection at a premium rate which would be affordable to the majority of those in need of long-term care. With private insurance affordable only for those with high incomes, and the (current) Medicaid system available only to those who have bankrupted themselves before meeting Medicaid criteria, this leaves a large middle class segment unable to afford care. Attempts to rely on "private insurance" does not relieve the American citizen from sharing the cost of long-term care; it only makes the cost more costly for those who do purchase insurance and increases the cost to all in maintaining an ever growing group dependent upon publicly supported care.

A long term program should be case managed to ensure the most effective care with quality . . . such case management would direct care in the home when the needs of the patient would be better served in the home. Inherent in the development and implementation of such a program would be a national effort to educate and train sufficient personnel to handle the needs of a long term health care program. Among the many needs of individuals in long term programs are those necessary to enhance the lives of those with unique disabilities such as blindness. Therapies such as Orientation and Mobility and daily living skills for the blind and severely visually impaired and low vision services not only help keep individuals out of nursing homes, they assist in the provision of assistive services in both the home and in nursing homes.

The United States should not be one of the two developed industrial nations in the world that does not have a comprehensive medical and long-term health-care system to which its citizens can avail themselves when in need. We should not await a time of crises before preparing such a program.

AMERICAN MEDICAL ASSOCIATION
535 NORTH DEARBORN STREET • CHICAGO, ILLINOIS 60610 • PHONE (312) 645-5000 • TWX 910-221-0300

JAMES H. SAMMONS, M.D.
Executive Vice President
(645-4300)

August 10, 1988

The Honorable Fortney H. (Pete) Stark
Chairman
Subcommittee on Health
Committee on Ways and Means
United States House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

Re: Submission for the Record of the
August 4 Subcommittee Hearing on
Long-Term Care Insurance

Dear Chairman Stark:

The American Medical Association requests that its report, "Policy Directions for the Public Financing of Long-Term Care Services," be included in the record of the August 4 Subcommittee on Health hearing on the need for long-term care insurance.

The report, which was adopted by the AMA's House of Delegates in June of this year, details the principles the AMA will follow in developing and supporting initiatives to provide adequate coverage for long-term care services to people who need these services.

As the report indicates, the AMA has adopted a principle to encourage privately prefunded long-term care financing as well as a principle to assure access to needed long-term care services when personal resources are inadequate to finance care. The AMA believes that mechanisms for both private and public funding of long-term care will need to be established if adequate access to long-term care is to be provided.

The AMA is continuing to examine the variety of issues surrounding long-term care and looks forward to participating with the Subcommittee in seeking to resolve the many complex issues involved in this matter.

Sincerely,

James H. Sammons, M.D.

JHS/dlh
4046p

REPORT OF THE BOARD OF TRUSTEES

Report: O
(A-88)

Subject: Policy Directions for the Public Financing of Long-Term Care Services

Presented by: Alan R. Nelson, M.D.

Referred to: Reference Committee G
(William J. Reals, M.D., Chairman)

Recent Association policy activities on Aging have focused on restructuring health care financing arrangements. With the adoption of Board of Trustee Report S (I-87), the Association expressed support for the growth of private long-term care financing arrangements while recognizing the need to reform public long-term care financing for the poor. This report focuses on public financing of long-term care services for the elderly poor and recommends principles for evaluating or developing long-term care financing proposals.

Background

The unanticipated, often catastrophic, cost of long-term care (LTC) and the lack of insurance protection for this risk are major causes of impoverishment among the elderly. Approximately one in five individuals who live to age 65 will spend some time in a nursing home or will require intensive home health care services before they die. For at least half of the elderly population, the cost for nursing home or intensive home care services represents a catastrophic financial event. For society, the LTC demands of an aging population and the escalating cost of LTC services seriously challenge the capacity of the public health care financing programs.

Between 1980 and 1986, Medicaid, the country's principal public financing program for LTC, experienced a 73 percent increase in expenditures for services to the elderly, rising from $8.7 billion in 1980 to $15.1 billion in 1986. For many states, Medicaid expenditures represent the fastest growing budget line item and rank second only to funds for education in amount of public dollars spent for human services. Yet, despite the large and growing commitment of public dollars, the majority of the population remains economically vulnerable to the cost of LTC.

By the year 2020, the age 65 and older population in need of LTC services is expected to increase 83 percent to 22.3 million individuals. Broader participation in privately prefunded LTC financing will reduce the claims made on public health care financing programs by the middle class, but this phenomenon is not expected to eliminate the need for public assistance in financing LTC services for the elderly poor. Although private LTC insurance may be affordable for 26 to 45 percent of the elderly population by the year 2020, public expenditures for LTC services are projected to grow to $68.5 billion, an increase of 264 percent over the next 32 years.

Current System

The bulk of public dollars spent specifically on LTC services are Medicaid funds for nursing home care. Formal community-based and in-home LTC services are provided nationally under Title XX of the Social Security Act and Title III of the Older Americans Act, as well as under Medicare and Medicaid. Title XX is a federal population-based block grant program to the states for social services primarily provided for low income persons. Services under the Older Americans Act are extended to all persons age 60 and over without regard to income.

Medicaid, a federal and state program, provides health care coverage to select categories of low income persons including the elderly poor. It is the principal public financing program for LTC, and many of the shortcomings in the financing and delivery of LTC services in this country have been tied to deficiencies in this program. Deficiencies in the Medicaid program which have direct impact on long term care include:

- o Inequities that arise from state variations in eligibility criteria and standards;
- o Inadequate coverage of the population in need of public LTC protection;
- o A bias toward the use of institutional services, principally nursing homes;
- o Inadequate support for community-based care; and
- o Inadequate support for family care givers and other informal support systems.

State determinations of Medicaid eligibility for the elderly involve complicated regulations that not only vary from state to state but are frequently confusing to applicants, recipients, providers, and program administrators. Restrictive Medicaid eligibility rules and the dearth of affordable, comprehensive private LTC coverage leave most of the elderly population unprotected against the impoverishing effects of LTC.

Medicaid programs require persons facing major LTC costs to exhaust their income and assets before they are eligible to receive public assistance in purchasing care. Once impoverished, it is difficult to arrange a discharge back to the community. Private LTC insurance coverage is growing but currently accounts for less than one percent of the nation's total LTC bill. Nearly half of all nursing home patients exhaust their private funds within 13 weeks of admission and become dependent upon public programs to meet the cost of care.

The Medicaid program's dominance as the major third-party purchaser of LTC services has had a profound impact on the availability and use of LTC service. The program's bias in covering institutional/nursing home care over home care or other community-based services has contributed to inappropriate utilization patterns and high program costs. According to the 1987 National Center for Health Statistics survey of nursing home use, more than half of the 1.5 million residents in nursing homes are there not because of severe medical problems but because they need assistance with activities of daily living and have either outlived their family support system or require levels of assistance--not necessarily medical assistance--beyond the capacity of family care givers.

Nursing home expenditures annually claim over 80 percent of Medicaid expenditures for the elderly and 42.7% of the total Medicaid budget. By the year 2020, public expenditures for nursing home services alone are expected to increase to $50.7 billion.

Current Policy Activities

Growing national concerns over the number of elderly persons impoverished by LTC bills and the rising cost of Medicaid coverage for LTC services have prompted government officials to look for ways of restructuring LTC financing. Many of the public policy proposals focus on reforms to the state Medicaid programs and address the LTC financing needs of the current generation of older adults. These activities include:

- o Limiting the supply of LTC services through moritoriums on the construction of new nursing homes and encouraging community-based LTC services.

- Preadmission screening for nursing home placement to prevent inappropriate institutionalization and to contain Medicaid costs.
- Community and home care waiver programs to offer Medicaid recipients a variety of home and community-based services as alternatives to institutional care.
- Alternative reimbursement methods that include prospective payment for Medicaid services or payment systems tied to case mix or intensity of care measures.
- Shifting of payment sources to enforce familial responsibility laws.
- Support of informal caregiving through reform of Medicaid spend-down requirements, the provision of tax credits and other subsidies for caregiving, and the funding of respite, adult day care, and other community-based services.

These activities work within the existing public financing systems. Their impact on the cost and accessibility of LTC services, to date, have been mixed.

Future Policy Directions

Several bills addressing LTC financing are expected to be introduced during the current congressional session. These bills will include new LTC financing programs that greatly expand the federal government's role and that emphasize the prefunding of LTC for future generations of elderly.

Policy proposals that have attracted national attention and that may come before Congress this year include:

- The elimination of LTC financing under Medicaid and the development of a separate Medicare program for LTC with its own designated trust. Major features of the program include universal mandatory participation through the tax system or the use of income adjusted premiums; the provision of a basic level of LTC coverage to all; and the use of a voucher program for the purchase of private LTC coverage.
- The expansion of existing Medicare coverage to include home care service for Alzheimer victims and other groups of chronically disabled persons.
- The replacement of state Medicaid entitlements with state bloc grants funded through the consolidation of major LTC health and social service programs.
- Provision of universal catastrophic coverage for LTC, eliminating the spend-down requirement of the Medicaid program and limiting publicly financed coverage to expenses that either exceed a specified amount or that represent a catastrophic claim on an individual's or a family's financial resources.

The development of a national LTC financing program represents a dramatic shift in LTC policy that, as yet, has not received widespread support. Over the past decade, the federal government has shifted more of the responsibility for LTC to the states. Recent congressional deliberations on health policy have been marked by an overriding concern with reducing the federal deficit. The political environment is one of retrenchment and not of expansion, and yet there is growing national sentiment that new LTC financing arrangements need to be developed.

The Role of the Association

Rising national concern over LTC issues has been accompanied by the rapid emergence of many innovative but widely varied LTC financing proposals. Given this environment, the Board believes that Association endorsement of a specific approach or development of detailed operational and contractual standards for LTC financing mechanisms is premature at this time and would unnecessarily limit the Association's involvement in the public debate of alternative policy options and funding strategies. Over the next year the Association will continue to be active in LTC policymaking by:

- Monitoring congressional and state activities addressing LTC financing;
- Advocating LTC financing approaches that are consistent with the principles stated below; and
- Developing recommendations for modifying public LTC financing programs and private LTC insurance mechanisms and supporting federal, state, and local efforts to implement changes consistent with these recommendations.

As noted in other reports before the House at this meeting, detailed study is now underway by the Board, Council on Medical Service, and Council on Legislation of potential modifications in Medicaid financing of long-term care services. These activities will be the basis for future recommendations to the House.

Recommendations

The Board recognizes that the financing of LTC is an important public policy and health care issue. Through Board of Trustees Report MM (A-86), Council on Medical Service Report F (A-86), and Board of Trustees Report S (I-87), the Association has examined many of the key policy issues in LTC financing and has already considered a variety of LTC financing options. Consistent with the findings of these reports, the Board recommends that the House of Delegates adopt the following principles for LTC financing:

- The encouragement of privately prefunded LTC financing to the extent that personal income permits;
- The assurance of access to needed services when personal resources are inadequate to finance care;
- The protection of personal autonomy and responsibility in the selection of LTC service providers;
- The prevention of impoverishment of the individual or family in the face of extended or catastrophic LTC costs;
- The coverage of needed services in a timely, coordinated manner in the least restrictive setting appropriate to the health care needs of the individual;
- The coordination of benefits across LTC financing programs; and
- The promotion of family caregiving.

The Board believes that these principles serve as a framework by which to evaluate or develop both public and private LTC financing proposals and should be part of a national LTC policy.

STATEMENT OF THE
AMERICAN SOCIETY OF INTERNAL MEDICINE
TO THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
ON LONG TERM CARE

SEPTEMBER 26, 1988

The American Society of Internal Medicine (ASIM), a national organization representing more than 20,000 physicians specializing in internal medicine, appreciates the opportunity to submit a statement for the record on the serious problem of providing long term care for the nation's growing number of elderly citizens. ASIM believes that while the catastrophic legislation passed by Congress is a significant step forward, it does not go far enough since it is silent on coverage for long term care. As the population ages, the need for long term care for chronic illness will increase dramatically. Between now and 2010, the elderly population is expected to grow by 10.6 million people; most of the growth (5.9 million) will occur in the 80-and older age groups.

Long term care, specifically nursing home stays, is the primary source of "catastrophic" out-of-pocket health expenditures for the elderly. About one-half of the approximately 1.2 million elderly who will be admitted to nursing homes in 1988 will have out-of-pocket expenditures greater than $5,000 for their entire length of stay and over 10 percent will have out-of-pocket costs of over $50,000.

A major reason for these high out-of-pocket costs has been the lack of private sector insurance options and limited coverage by public programs. While some insurance companies are beginning to offer long term care coverage, these policies are still limited in number and due to their high cost, unaffordable for a significant number of elderly. The Medicaid program picks up the bulk of long term care costs, 41.8 percent, but individuals usually must "spend down" their resources in order to qualify. Furthermore, Medicare's nursing home benefit is extremely limited in scope; the program provides coverage for nursing home care and home health care only after a limited period of time following an acute illness requiring hospitalization. The catastrophic legislation will augment to a small extent the skilled nursing benefit provided under Medicare and waive the prior hospitalization requirement.

Public/Private Sector Approach

ASIM believes that both the public and private sectors should have major roles in financing long term care. This approach fosters personal responsibility for dealing with the problems of aging, but improves the chances that the elderly will obtain care they need. ASIM supports an approach which reflects the view that neither the public nor the private sector can be expected to carry the full burden of paying for long term care.

One approach, similar to the legislative proposal (S.2305) introduced by Senator Mitchell, would expand Medicare to provide a modest long term care benefit, to be supplemented by private insurance and other resources. Under this approach, Medicare would cover long term care only after a dollar amount or a specified duration period has been reached. Up to this point an individual would be responsible for providing for their own long term care needs through private insurance, long term care IRAs or other personal resources.

Establishing an exclusionary period, would encourage insurance companies to offer long term care insurance since their risks would be definitive and limited in time. Limiting the time for which an individual would need insurance would also have the effect of lowering premiums and making the purchase of long term care insurance a more affordable option for the elderly.

The Role of Private Health Insurance

The success of a private and public sector approach to financing long term care will depend on the response of the private insurance industry and its ability to design and market affordable insurance policies. We believe that Congressional action to encourage private insurance is essential to further market development and to make it more affordable. Otherwise many people will continue to impoverish themselves much as they do under the current system.

Although private long term care insurance has been underutilized, it is important to note that in a relatively short period of time the number of insurance companies selling long term care insurance has reached over 70 companies. Nonetheless, financial liabilities of insurance companies remain uncertain because (1) nursing home use may increase beyond current estimates; and (2) adverse selection may occur if a disproportionate number of individuals who know they will use long term care services purchase insurance. In addition, because long term care is needed primarily by the very old, an insurance policy bought at age 65 may not be used until age 85. An insurance company may not know for 20 years if the policy initially sold to people 65 years old was priced properly, and by then it is too late to change premiums to pay for needed benefits.

Assuring the Availability of Long Term Care

To encourage expansion of the private market, ASIM recommends the use of tax incentives for the development and purchase of long term care insurance. ASIM believes that the tax code should be changed to allow: 1) the same tax status to long term care products as now exists for accidental and health insurance; 2) deductibility of insurance reserves and related investment earnings; 3) inclusion of long term care benefits in cafeteria plans; and 4) tax credits for the purchase of long term care coverage. In addition, prefunding of retiree acute care benefits and long term care insurance should be encouraged as a way of reducing the economic burden of the next generation and of lowering the cost of benefits.

While it is desirable for the private sector to have a greater role in financing long term care, ASIM realizes that such private initiatives will do little to protect those in lower income groups or prevent many individuals from spending down their assets to become eligible for Medicaid coverage. (The Brookings Institute estimates that by 2018, private long term care insurance will be affordable by 25 to 45 percent of the elderly, may account for 7-12 percent of nursing home expenditures and reduce the number of Medicaid nursing home patients by 5 percent.) ASIM supports legislation to expand eligibility standards under the Medicaid program for individuals with incomes at or below the poverty level, and to provide protections for the income and resources of an individual whose spouse is institutionalized.

Enhance Consumer Protection in the Long Term Care Insurance Market

ASIM applauds the Chairman's efforts to introduce legislation to provide for federal and state standards for private long term care policies, along the lines now used to regulate Medigap policies. The Subcommittee is well aware of the problems associated with the provision of Medigap coverage and the unnecessary costs expended by the elderly in the mistaken belief that the policy purchased will provide the coverage needed. Safeguards must be established and consumers must be educated as to the limitations of coverage. The federal government and states should play an important role in regulating the insurance industry to assure appropriate standards of coverage, the establishment of guidelines for proper disclosure, protections against sales abuses, regulation of requirements of renewal and cancellation, requirements for sufficient reserves, and the development of benefit/premium ratios.

Financing of Long Term Care Benefits under Medicare Program

ASIM believes that there should be a self-financing mechanism to pay for the additional benefits that would be added under Medicare, and that safeguards should be established to ensure that this would continue to be the case in the future. We support the use of an income-related premium to shield low income beneficiaries from excessive out-of-pocket expenses and to raise the premium for those beneficiaries who can afford to pay more for the cost of this care. ASIM also supports tapping other sources to further protect beneficiaries from high out-of-pocket expenses, including 1) increasing the excise tax on alcohol and tobacco and earmarking at least a portion of the revenue to Medicare; and 2) imposing the Medicare payroll tax on currently exempt state and local government employees.

In conclusion, ASIM appreciates the opportunity to share its recommendations to improve our federal long term care policy. Major new initiatives are needed in both the private and public sector to improve financing of long term care. Since relying on a welfare program to finance long term care for a large percentage of the population is undesirable, ways should be found to expand Medicare coverage to include long term care and to encourage the development of the long term care insurance market. ASIM looks forward to working with the Subcommittee as it deliberates over the development of a national program to provide for the long term care needs of this nation's citizens.

M-PKH-1318

CONGRESSMAN FRANK ANNUNZIO'S TESTIMONY ON LONG-TERM HEALTH CARE GIVEN BEFORE THE SUBCOMMITTEE ON HEALTH OF THE HOUSE WAYS AND MEANS COMMITTEE

AUGUST 2, 1988

MR. CHAIRMAN: I commend you on your efforts in holding these hearings on long-term health care for the elderly and disabled, and I appreciate the opportunity to testify on behalf of my constituents who support the passage of comprehensive long-term health care legislation.

As you know, on July 1, the Medicare Catastrophic Coverage Act of 1988 became Public Law. This legislation was a crucial first step in addressing the critical health care needs of our senior citizens. However, it did not go far enough in providing for important long-term needs of our nation's elderly and disabled.

There is still no Federal program in place to help people pay for their long-term health care needs. Perhaps one of the greatest fears confronting the elderly today is that their lifetime savings may be completely wiped-out by unanticipated long-term health care needs. This is precisely the expense that our senior citizens fear the most, because at an average annual cost of $20,000, most Americans are bankrupt within one year after entering a nursing home.

Our nation has not done a very good job of helping people with long-term needs. Under current Federal programs, individuals must first use up all of their savings and income accumulated during a lifetime of hard work before receiving benefits--and even these benefits do not cover the complete cost of the care.

When it comes to home care for the elderly and disabled, the situation is even worse. What we spend on home care services is only a fraction of the amount currently spent on nursing home care. This support is fragmented over a number of programs that make it difficult for our chronically disabled to figure out where to go for help. If they do manage to make some sense of the system, they are more likely to find out that they cannot qualify for assistance, or that resources are not available. It is for these reasons that I am a cosponsor of Congressman Claude Pepper's bill to provide Medicare long-term home care benefits, and I am hopeful that in the future the Congress will take the steps necessary to address this serious need.

As you are aware, national studies have shown that elderly persons prefer to remain in their own homes as long as possible. I know from personal experience in my own District in Illinois that this is the case. There are many elderly persons living in the 11th Congressional District of Illinois, and my constituents tell me they want and need more home care services for their disabilities. They want to avoid entering a nursing home at all costs. Some tell me that they are lucky enough to have family members provide care that makes a real difference in their ability to remain at home. However, most disabled or elderly Americans, who are fortunate enough to remain in their homes, do need more home care services, despite the dedicated support they are fortunate to receive from family and friends.

Sometimes their only source of help is a spouse who is also elderly and disabled. As we live longer, more and more elderly persons have children as their caregivers who themselves are retired. Others are not so lucky as to have a family member present or nearby to help with their needs. These individuals are asked to survive on their own. My constituents are no different from any other Member's constituents, and we can no longer turn our backs on these needs.

Trapped in this maze of inadequate Federal protection, private long-term care insurers have stepped in to fill the need. Unfortunately, long-term health insurance rates continue to increase, and sometimes insurance companies have taken advantage of the fears of the elderly--persuading them to purchase worthless policies, or policies which promise a lot more than they can deliver.

Mr. Chairman, the time has come for us to take the monumental step of providing for long-term health care for our elderly and the disabled. I commend you again on holding these hearings, for we must continue our efforts to resolve satisfactorily the issues of providing adequate and affordable long-term care, while at the same time bringing the increases in insurance premium costs to a halt.

Thank you, Mr. Chairman.

[THE HONORABLE BERYL ANTHONY REQUESTED THE FOLLOWING TESTIMONY BE SUBMITTED FOR THE RECORD, WHICH HE RECEIVED AT AN INFORMAL HEARING HE HELD ON LONG TERM CARE IN HOT SPRINGS, ARKANSAS, ON OCTOBER 22, 1988.]

TESTIMONY BEFORE

CONGRESSMAN BERYL ANTHONY, JR.

October 22, 1988

Hot Springs, Arkansas

by

Holly Roos
Project 2000 Director
Arkansas Department of Human Services
Division of Aging and Adult Services

Thank you for inviting me to discuss long term care and the needs of the elderly in Arkansas.

I would like to begin with a description of the demographics of the elderly in Arkansas. Additionally, I will provide you with a draft copy of a profile of older Arkansans which will give you information from the census and other sources. Our state has one of the highest percentages of elderly: approximately 14.2% of the population is 65 years of age and older and 18% is over the age of 60. By the year 2000, the percentage of elderly is estimated to be about the same, but the growth in pure numbers of elderly persons will be dramatic, especially for the old-old. Those 65+ will increase 26%, those 75+ will increase 70%, and the 85+ will increase 150%. This dramatic increase in the 85+ will present challenges to the health care and especially the long term care system. Chronic conditions render the elderly person less able to live independently by causing impairment of the skills needed to take care of oneself. The elderly population will increase even more dramatically between the years 2010 and 2030 when the baby boomers begin turning 65. By 2030, we may have twice as many elderly as we did in 1985.

Arkansas has the third highest poverty rate among elderly. Approximately 28% of the elderly were below the poverty level in 1979; 40% were below 125% poverty. Ten counties had poverty rates above 40%. (Poverty income for a single person this year is $5770.) Persons with lower incomes are more likely to be impaired and to require assistance in managing and living independently.

The Division of Aging and Adult Services enables elderly Arkansans to receive some of the services they need through both federal and state funding sources. Many of these services are contracted or provided by the Area Agencies on Aging. Through the Older Americans Act, Social Services Block grant and the US Department of Agriculture, the state receives approximately $15 million. State general revenues contribute approximately $9 million in addition. These dollars provide congregate and in home-meals (3.5 mil meals per year), employment programs for 800 older workers in the form of training and subsidy, 210 Senior Centers for socialization, 350 vans for transportation, case management and nursing home alternatives such as personal care, chore, adult day care, plus a portion of the match for Title XIX (Medicaid) personal care services. Services provided through the Medicaid program include home health care (approximately $6 million in state and federal funds), personal care ($15 million) and private nursing home ($129 million). Attached to this statement is a chart of Medicaid vendor payments for all services to all Medicaid clients. It shows that half the Medicaid budget is going to nursing home, home health and personal care services. We have seen an increase during the 1980s in the utilization of Medicaid home health and personal care while, at the same time, a stabilization in the use of nursing homes. The increase in nursing home expenditures has been the result of increases in nursing home reimbursement rates.

At this point, I would like to offer a definition of long term care for your consideration. Often, when people think of long term care, they think of the care received in a nursing home. However, Kane and Kane have defined long term care as follows:

> Long term care is a set of health, personal, care and social services delivered over a sustained period of time to persons who have lost or never acquired some degree of functional capacity. (Capacity in such cases is usually determined by an index of functional ability.) ... long term care is the assistance that is needed to manage as independently and as decently as possible when disabilities undermine capacities.

The goal is to develop a long term care system which provides flexible, quality choices to the elderly person. Long term care may be provided in the home, in the community in congregate settings, or in an institution. The services provided should be based on the functional need of each individual. Long term care should be available to all who truly need it. Dignity and the right to take risks are imperative for the older person. This goal has not yet been accomplished, although there are many dedicated persons working towards it.

Our Division has been involved in two research projects during the past few years to assess the needs of older Arkansans and to develop new ways of meeting those needs. First, our office, in cooperation with the Area Agencies on Aging in Arkansas has recently published the Year One Report of the Arkansas Longitudinal Study on Health and Aging. This is a survey of over 4,000 households including more than 6,100 individuals 55 or older.

The survey found that the most common health problems were chronic in nature and include arthritis, high blood pressure, hearing difficulty, heart condition and eye diseases. Female elders reported more health problems than male elders, black elders reported more problems than white elders, older elders reported more problems than younger elders, and lower income elders reported more health problems than higher income elders. Forty percent of elders reported impairments requiring assistance in Activities of Daily Living (bathing, dressing, eating, toileting, mobility), and managing cooking, light housework, shopping, laundry and other tasks which measure an individual's ability to live independently. The older the age cohort, the greater the impairment of ability to physically care for oneself, to manage independently, and overall to live independently. These elders will require the most long term care services. This study will allow us to estimate the need for various types of services and to follow the changes in these needs annually for a total of five years.

The other research effort is Project 2000, provided by a grant from the Administration on Aging for two years to study the long term care system in Arkansas and long term care systems in other states and to make recommendations for the development of a comprehensive system of long term care for our state.

In its investigation of state long term care systems, Project 2000 staff has found many approaches to the organization, delivery and financing of long term care. The unique features of a state will influence the development of successful systems. In Arkansas, as in most states, the institutional level of long term care is well developed. This is in part because funding is biased towards those is institutions. Home and community-based services are not developed to the extent that meets the true needs of individuals. Some states rely more heavily on state general revenue for funding long term care programs. The advantage here is the flexibility available with state funds which is not present when using federal funds. States can provide a broader range of services, be more generous with eligibility requirements, have different categories of providers, and target services to the individuals the state feels are most in need.

Other states rely more on Medicaid for funding. This is a state program but a portion of the funding comes from the federal government. In Arkansas, the federal government contributes almost 74% of the reimbursement for Medicaid services. This makes Medicaid very attractive for our state. However, Medicaid brings with its programs many federal rules, regulations, and exclusions as well as its restriction on income. People can not qualify unless they are impoverished and, in Arkansas, below the poverty level. The other problem is that the income eligibility for nursing home care under Medicaid is three times that of the income eligibility for in-home and community-based services. Therefore someone with an income between SSI ($354/month) and 3 x SSI ($1062/month) could qualify for Medicaid if he or she were in an institution, but not if he or she were living in the community. It is not possible to offer a non-institutional alternative to this person. The one way to solve this problem is through a Medicaid 2176 waiver, which allows states to waive some of the Medicaid rules and offer services different from those allowed within the regular Medicaid program. In this case, the income for those who meet the medical criteria for nursing home admission could be the same as for nursing home. The state could in fact offer true alternatives to nursing home and the services provided could be structured to meet the needs of the long term care client. This sounds like the solution to the problem! But, it's not quite that easy. Waivers are difficult to write, to get approved, and to administer. Many staff hours are required. Also, there is a limit to the number of persons that can be covered under the waiver which reflects the vacancy rate and turnover in nursing homes. The expenditures under the waiver can not exceed the expenditures expected in the absence of the waiver, assuming these persons would have been in nursing homes. Presently, the Department of Human Services is drafting a waiver which will be able to cover approximately 2000 persons. When it is implemented, it will offer better community and in-home alternatives to nursing home placement for a limited number of individuals.

The Division of Aging has requested additional state funds for the next biennium which would allow a wider variety of in-home and community-based services, especially those that are less medically oriented. Also these funds would allow persons with a wider range of income to receive assistance with their long term care needs. Income eligibility levels could be set above those for Medicaid and sliding fees could be used so that the elder would contribute to the cost of care based on income. However, it is likely that the state will not be able to afford the kind of commitment to long term care necessary to truly meet the needs of its citizens.

Many persons entering a nursing home are private pay patients who, after spending down and becoming impoverished, become Medicaid eligible. Our information on poverty rates indicates that most individuals (60%) will have impoverished themselves within 13 weeks of being in a nursing home and thereby become eligible for Medicaid. Many persons cannot afford the cost of in-home or community-based care. In 1979, 74% of Arkansas' elders had incomes of less that $6000 per year, 88% had incomes less than $10,000. Obviously, it is going to be difficult for most Arkansans to afford long term care if they need it and it will continue to be difficult and almost impossible for the state to provide funds for the kind of long term care system the elderly in this state deserve. As long as the funding for these alternative services is primarily within states' budgets, inequities will occur throughout the nation. Some states will have the tax base, the revenue and the commitment to pay for a good long term care system. Others will not. The solution to this problem is a national pooling of the risk and a federal involvement in the creation and funding of comprehensive long term care systems in all states for all citizens.

I would like now to make some recommendations for improvements in the federal approach to long term care which would allow the state of Arkansas to better meet the needs of its elderly citizens.

1. Allow the provision of a broader range of long term care services under the regular Medicaid program so that more appropriate in-home and community-based services could be offered. Require pre-admission screening based on functional need for the individuals seeking these services so that they will be provided only to those who truly need them.

2. Allow persons with incomes up to 3 x SSI to be eligible for the Medicaid nursing home alternatives described in (1).

3. Revamp the federal/state system of health care for the elderly so that long term care is available to all elderly persons regardless of income. Continue to have the control of the program development at the state level. I believe the fairest and most economical way to fund the system would be to require cost sharing for services according to ability to pay. This could be in the form of a sliding fee scale. Persons would be assessed to determine the most appropriate care based on a functional assessment. Every effort would be made to allow persons to remain in their own home or in the least restrictive setting possible by maintaining flexibility in the type of long term care available.

In closing, I see some improvements in the long term care system for Arkansas in the near future. However, if we are to create the kind of system we want and deserve for our elderly citizens, major changes must be made in the public sector with respect to long term care. Flexibility is needed in the types of services and in the resources available to help pay for these services.

Thank you for the opportunity to appear at this hearing.

STATEMENT OF
REP. DOUGLAS H. BOSCO
ON LONG-TERM CARE INSURANCE

BEFORE THE
COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH
August 2, 1988

MR. CHAIRMAN -- I appreciate the opportunity to provide testimony to the committee on the need for long-term care insurance for our nation's elderly and disabled.

I am convinced that the current long-term health care delivery system has proven incapable of meeting the needs of the chronically ill and their families. I therefore fully support this committee's decision to investigate the long-term care problem, and I hope that we can soon arrive at a means to provide federal assistance to those who must endure long, painful, chronic illnesses at home. There is ample evidence, Mr. Chairman, that supported care at home can be less expensive, and often more effective and humane, than care in a convalescent home.

To illustrate the need for this kind of assistance, I would like to cite the example of Frank and Arlene Boomer, my constituents in Mendocino County, California.

Frank, now 59 years old, has had Lou Gehrig's disease for seven years. This disease produces a gradual deterioration of muscle control, affecting in its advanced stages even the involuntary muscle systems. For the past several years, Frank has required increased levels of assistance with every aspect of daily living. He is now unable to move except for one wrist, and he has been on a respirator for three years.

His daily care is a massive job. He must be moved, bathed, toiletted, and fed through a gastrostomy tube. The trachea tube for the respirator must be cleaned and suctioned every hour, day and night, to prevent a life-threatening accumulation of fluid in his lungs. There is simply no detail of living with which Frank does not need total assistance.

Since none of this care requires the services of a skilled nurse, Frank is not eligible for Medicare reimbursement for the cost of the licensed vocational nurses that his wife, Arlene, must hire so that she can get some rest and have time to do grocery shopping, daily chores, and so on.

If Frank were admitted to a convalescent home, California's medical insurance program (Medi-Cal) would pay for his care once the resource limit was met. However, the nearest convalescent home which is equipped to deal with respirator patients is located 150 miles from Frank's home in rural Mendocino county. His family has opted to keep Frank at home so he can enjoy the contact with his family and friends during the last days of his life. The advantages to Frank in remaining at home -- medical as well as psychological -- cannot be overstated.

The cost of Frank's care at home is actually far less than it would be if he were in a convalescent facility. At present, Arlene is assisted by licensed vocational nurses for seven hour per day, four days per week. At the rate of $7 per hour, the monthly cost is $784. This is all that the family can afford, though it is apparent that Arlene needs more help than she is receiving.

In 1986, I requested an administrative waiver of the Health Care Financing Administration's regulation to allow Medicare reimbursement for the cost of the licensed vocational nurses that assist Arlene. This waiver was denied, even though the total cost would have been less than the cost of Frank's care in a convalescent facility. The cost to the federal government would have been $1568 per month for eight-hour-per-day, seven-day-per-week assistance from licensed vocational nurses. The convalescent home estimated that Frank's care would cost between $3000 and $3500 per month. Keep in mind, Mr. Chairman, that current law provides reimbursement for this higher figure -- once an individual meets the resource limit -- but not for the less costly in-home assistance.

With only seven hours of assistance on four days or nights each week, Arlene is exhausted. I can only admire her courage and stamina. Mr. Chairman, I believe that the federal government should ensure that all families such as the Boomers are assisted with this incredible task, and I look forward to a time when long-term care will be more readily available.

Mr. Chairman, despite the overall success of the Medicare program, there is growing concern in our society over the large gaps in its coverage, as Frank Boomer's situation so aptly illustrates. I supported the recently enacted catastrophic care legislation because I believe that it is an important first step in building a more effective Medicare program. The new law now protects seniors from the catastrophic expenses of hospitalization, doctor bills and prescription drug costs.

Having achieved this needed protection, I applaud the committee's decision to turn its attention to the other catastrophic health care crisis -- the lack of coverage for long-term home care. I look forward to working with you to ensure that the Medicare program will ultimately provide comprehensive, compassionate, and cost-effective health care for our nation's elderly.

Frank Boomer was a skilled carpenter by trade. His fine carpentry work in Mendocino County is an enduring testimony to his many contributions to life in my part of the country. I sincerely hope that our work on long-term home care can match, in humanitarian terms, the beauty and endurance of that testimony.

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STATEMENT OF DONNA COHEN, PH.D.
BEFORE THE SUB-COMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
SEPTEMBER 26, 1988

Mr. Chairman and members of the Subcommittee on Health, I am Dr. Donna Cohen, Professor of Gerontology and Community Health Sciences in the School of Public Health and Deputy Director of the Gerontology Center at the University of Illinois, Chicago, Illinois. I appreciate the invitation to testify on long-term care for Medicare elderly and disabled beneficiaries, specifically those persons with Alzheimer's disease and related disorders.

There is a growing need for long-term care in America at a time when health care costs are soaring, driven by several cost-generating forces, including a growing population, the increasing longevity of the oldest age groups, the increasing medicalization of social problems, and the growing AIDS epidemic. The percent of the GNP going into health care rose from 10.5% in 1982 to 11.2% in 1987. Insurance premiums are now in the 20% plus range. The challenge for Congress, the next President, and the American people will be to shape a national long-term care policy for an aging population, constraining the burden on younger persons and the nation's overall resources.

The phenomenon of more people living longer and older people experiencing increased life expectancy has never been witnessed in the history of our world. In 1900 only 25% of people lived beyond age 65, but by 1965 approximately 75% survived to age 65. Currently, more than 20% of our population dies after age 80, and if present trends continue, within the next 10-12 years half of all deaths will occur after age 80! The late age at which people are dying is the major reason we are struggling with the complex economic, social, and ethical issues of long-term care.

Death rates have declined greatly since 1900. A steep decline persisted from 1900 until about 1950 and then suddenly plateaued for almost a quarter of a century. During those years it was erroneously assumed that Americans had achieved a maximum life expectancy of age 67, and both Social Security and Medicare policies developed under this faulty assumption. In 1968 a sharp decline in mortality resumed and continues today. We do not know what is causing the continuing life extension or at what point it will slow down. However, the central health issue raised by increasing longevity is net gain of active, functional, and happy years of life versus total years of compromised health spent in pain and misery. The latest U.S. data suggest that for each year of healthy active life gained in our population, we are also adding about 3.5 compromised years! Increasingly, the challenging problems of the aged are non-fatal disabling conditions such as blindness, deafness, osteoarthritis and other joint problems, as well as Alzheimer's disease and related disorders.

Long term care is among the most significant ethical, social, and economic issues facing our society in the decades ahead. The rapid aging of society and the rising numbers of chronically diseased and injured human beings across the age spectrum--babies born with congenital or genetic disorders, those with AIDS, diabetes, renal disorders, hematological and cardiovascular disorders, schizophrenia, mental retardation, quadrapalegics, Alzheimer's disease and related disorders--have created a moral battlefield over caring and the value of life. In a recent book I wrote with my colleague Dr. Carl Eisdorfer, The Loss of Self, we stated "Caring and the value of human life are a part of our moral fabric. With the increasing numbers of persons with irreversible disease in our older population, already considered by many to be surplus to the productive capacity of the nation, the pressure to rethink our moral contract has already received national attention. The challenge is to find ways to help the helpless and ease the burden on the caring family."

The issue I wish to address here is whether we can afford to care for the growing numbers of older persons with Alzheimer's disease and related disorders as we confront the cruel facts of health care economics in our country. Individuals with Alzheimer's disease and other chronic mental illnesses are the largest category of seriously handicapped persons requiring long term planning and care. Unless miraculous advances are made in science and health management the following projection illustrates the magnitude and urgency of our social reality. There are now more than 2.6 million individuals with Alzheimer's disease and related disorders. By the turn of the century--twelve years from now--there will be over 4 million and by 2040 almost 9 million--or 1 in 30 Americans! These numbers, coupled with the numbers of individual family members, reflect the magnitude of the public health challenge of dementia and the human challenge to our society. Even if the cause or causes of Alzheimer's disease is discovered in the near future, we will still need to care for millions of patients and families well into the next century.

I come before this committee with a clear message from fifteen years of research and clinical experience in the fields of aging and long term care: We cannot afford not to care. Individuals afflicted with Alzheimer's Disease and related disorders are people first, last, and always! They usually live for 8 to 10 or more years with the disease(s), and those are long difficult years. Patients and their families are modern archetypal figures--heroes, victims, martyrs, and warriors--whose lives are tales of remarkable suffering, endurance, and courage. The absence of a national policy on long term care for the chronically ill has made living with Alzheimer's disease a herculean task for everyone. The odyssey of care often extracts an enormous emotional, physical, and financial toll because families provide more than 80% of long term care but are given little financial, professional or personal help throughout the course of the illness. Family members are vulnerable to the stress of caring. My research and that of others suggests that half of primary caregivers, those with daily responsibilities for the patient, develop a clinical depression. A number of studies have shown that anywhere from 1/3-1/2 of caregivers must leave work or cut down their hours to provide needed care. Thus, the absence of national policies of caring for the long-term as we all live, work, and depend on each other longer will continue to undermine the strength and indeed the health of the American family.

The magnitude and complexity of financing care for those with dementia are challenging. We can anticipate an unprecedented demand on our health delivery system as the number of persons increases. Individuals with Alzheimer's disease and related disorders do profit from many services--medical care, including psychiatric and rehabilitative care, as well as nursing, counseling and family support, social services and personal care. However, medical care costs may be less important than personal care and assistance as well as counseling and respite care for family members. It is clear that with appropriate resources and support, families maintain relatives with Alzheimer's disease at home, caring for them at least until the very late stages. Policies for long-term care should not completely medicalize a social problem. Policies should support the central role of the family, encourage and support the responsibilities of communities, and encourage an ethical relationship between providers and families.

A great deal can be done to maximize the functional effectiveness, health, and quality of life of patients with Alzheimer's disease and related disorders after their diagnosis. My colleagues and I are currently running an Alzheimer's Disease Patient Registry (ADPR) consisting of a central data management site at the University of Illinois at Chicago and five collaborating hospitals and medical centers in three states--Florida, Illinois, and Wisconsin. We are developing a base of knowledge about the complex relationship between the cost of caring and the quality of caring for persons with dementia. Over the past 6 months we have enrolled 516 patients diagnosed with Alzheimer's disease and related disorders at the Michael Reese Hospital and Medical Center in Chicago, Southern Illinois University School of Medicine in Springfield, Illinois, the University of Chicago School of Medicine, University of Miami School of Medicine, and the University of Wisconsin Medical School, Milwaukee, Wisconsin.

The 516 patients enrolled so far range in age from 47 to 97 years; 66% have Alzheimer's disease and 34% have a related disorder. Two-thirds are women and one-third are men. Twenty percent of them live alone and 38% live with spouses. The remainder live with other relatives with 6% institutionalized. At the time of diagnosis 17% had symptoms of agitation, 8% had other behavioral disorders, 18% had depressive symptoms, 7% had paranoia, 7% had hallucinations and 11% had other psychiatric symptoms. At the time of their diagnosis patients were rated for the ability to bathe, dress, eat, transfer, walk, and toilet. In bathing, 48% were able to do it easily, 14% had some difficulty, 13% had great difficulty, 9% were unable to bathe, and information was missing on 16%. When dressing ability was evaluated 52% were able to do it easily, 15% had some difficulty, 11% had great difficulty, 8% were unable to dress, and 14% had missing values. When eating ability was assessed 68% were able to do it easily, 8% had some difficulty, 5% had great difficulty, 4% were unable to feed themselves and 15% had missing values. When the ablity to transfer from bed to chair was evaluated 64% were able to do it easily, 7% had some difficulty, 7% had great difficulty, and 8% were unable to do so, with 14% having missing values. When walking ability was evaluated 66% were able to walk easily, 12% had some difficulty, 6% had great difficulty, 4% were unable to walk and 12% had missing values. When toileting ability was scored 63% were able to take care of themselves easily, 9% had some difficulty, 4% had great difficulty, 7% were unable to toilet themselves and 16% had missing values.

These data suggest several important recommendations: (1) The importance of sustained funding to the National Institutes on Aging for the Alzheimer's Disease Patient Registry projects; (2) The importance of removing Medicare discriminatory reimbursement provisions in outpatient and inpatient mental health services for dementia patients; and (3) The importance of expanding home care by refining regulations and reimbursement policies.

Alzheimer's disease is a metaphor for aging in our society. Our standard of care towards the most helpless reflects our value of sacredness of life. Not everyone will develop dementia as they age, but all men and women who survive premature death will grow older. The rapid aging our society guarantees that no individual nor institution will be untouched by the bittersweet success of increased longevity. Those of us who escape the ravages of chronic illness will be caring for those who are afflicted.

It has become apparent that Medicare and Medicaid as they now exist are not adequate to meet the needs of the chronically ill aged and their families. The enactment of the Catastrophic Health Act of 1988 does not meet the needs of persons with chronic illness and furthermore, it shifts the costs industry once assumed onto the already burdened beneficiary. Creative alliances between a broad range of private financing resources and government resources are needed. A plan to link community and medical services with preventative care and rehabilitation care are needed.

States have become the centerpiece of long term care policy making in the absence of a national policy. Although it is difficult to generalize since major differences exist between states the following directions seem to be clear: development of demonstration programs and day care, respite care and home care; new initiatives in funding nursing homes by capitation plans based on patient need; state laws directed at nursing home regulations including staffing requirements, staff training and tougher penalties for patient abuse and neglect; Alzheimer's special care units. Since 1985 many states have passed legislative initiatives in Alzheimer's disease, including specialized care settings, research and training, and family support.

If long term care reform is to succeed the various roles of federal, state, and local government need to be clarified and coordinated between levels of government, between agencies of government and between the public and private sectors. This coordination will only occur with a shared vision of what long term care should be and what it should cost.

Unless we are ready to come to grips with the impact of a rapidly aging society and long term care we are at great risk of plotting our own ruin and that of our families:

We are not onely passive,
But active in our owne ruine;
We do not onely stand under a falling house,
But pull it downe upon us;
And wee are not onely executed,
But we are executioners,
And executioners of ourselves.

John Dunne

STATEMENT BY REP. JACK DAVIS
BEFORE THE WAYS AND MEANS SUBCOMMITTEE ON HEALTH
AUGUST 2, 1988
ON
LONG-TERM HEALTH CARE

I want to express my appreciation to Chairman Stark for providing the opportunity for all Members to express our views on the long-term health care issue and commend the Subcommittee for holding these hearings. In the wake of the new Catastrophic Health Protection Act and the defeat of rule to consider Senator Pepper's home health care bill, it is important that Congress address the real issue at hand -- long-term home AND nursing care for the elderly.

I agree in principle with Senator Pepper's bill, but believe strongly that any legislation considered by this or the next Congress must include provisions for long-term nursing home care. When I talk to the Seniors in my district, they always ask, "What about nursing home care? When are you going to help us be able to afford it?" And they are right!

The Department of Health and Human Services found that "in 1984, the last year for which separate figures for the elderly population are available, the total health care expenditures for persons 65 and older exceeded $119 billion." This came from hospital care (45%) and nursing home care (21%). However, in terms of costs paid by the elderly themselves and not by Medicare, nursing home care was their single largest health care expense. Nursing home care accounted for approximately 42% of the elderly's total out-of-pocket payments.

I realize that the option of home health care is more attractive to a lot of Senior citizens and understandably so. But we can not ignore the facts--today average annual per capita expenses for nursing home care range from $22,000 to $25,000. And for those elderly spending more than $2,000 a year in out-of-pocket expenses for health care, 80% of their expenditures finance nursing home care.

I am an original co-sponsor of a bill proposed by Rep. Duncan Hunter (R-CA) which would institute changes the in Internal Revenue code making it easier for families to pay for the care of elderly family members. Under the "Long-Term Incentives Act of 1988," the tax code would be amended to allow a $10,000 deduction for a family member who takes care of a chronically ill parent, wife, brother, or sister in his or her home. In addition, the bill would provide a tax deduction equal to 50% of the amount paid or incurred for premiums for certified long-term health insurance. This type of legislation allows the family to decide whether the money would be used for home health care or nursing home care. I think that it is an attractive alternative.

As the Subcommittee continues its hearings, I am sure that it will come up with many different options for meeting the needs of our Senior citizens. It is my hope that the Subcommittee will consider alternative such as the Hunter bill which focus on making long-term care available to the family without creating another huge entitlement program.

Thank you for considering my comments and I look forward to considering a good piece of comprehensive long-term home and nursing home care legislation in the future.

Statement of Congressman Duncan Hunter
to the Ways & Means Subcommittee on Health
concerning Long-Term Care Legislation
August 2, 1988

MR. CHAIRMAN, I thank you for the opportunity to speak to you today on a subject that is of vital concern to our citizens and our economy. Long-Term Care policy has been a hot topic here on Capitol Hill and around the country. The actions that we take in Congress, will set the nation's elderly and long-term care policies for many years to come. We must be extremely careful when drafting new legislation, because we might have only one chance to get it right.

It seems to me, Mr. Chairman, that there is one fundamental difference in the types of long-term health care that have been offered in Congress. One faction seems to put its trust in the hand of government. This group believes that if we expand the role of the federal government we can care for the health needs of all elderly Americans. What often results is an inefficient, expensive, unbending bureaucracy that rarely delivers what it advertises. While doing this we manage to snuff out any new, inexpensive, or efficient solutions that private industry might offer.

The other group, in which I consider myself, believes that the solutions to long-term health problems lie with the American family, the individual, and in business solutions. With this in mind I recently introduced H.R. 4929, the "Long-Term Care Incentives Act of 1988." This bill would amend the Internal Revenue Code to allow a $10,000 deduction for an individual that cares for, in the individual's home, a chronically ill, Medicare eligible family member. If passed, H.R. 4929 would apply to taxable years beginning after December 31, 1987.

Chronically ill status must be certified by a physician and is defined as being unable to perform at least two acts of daily living. Acts of daily living are defined as bathing, dressing, toileting, transfer (getting in and out of bed), and eating. The tax deduction would also be available for individuals who care for family members who are similarly impaired because of a cognitive illness, such as Alzheimer's or Parkinson's disease.

A cost estimate is currently being worked up for H.R. 4929, but whatever the revenue loss for the IRS, I believe the enactment of the Long-Term Incentives Act would be much cheaper than institutionalizing or hospitalizing our chronically ill senior citizens. I agree with the statement that the American family is the first and best Department of Social Security and Health. I think that, given the choice, seniors would prefer a family member's home over a nursing home. I'm sure that a loving, caring family environment is more conducive to the healing process than a nursing home.

In addition, we must plan of the future long-term health care needs for our working age citizens. H.R. 4929 also amends the I.R.S. code to allow a deduction equal to 50% of the amount paid by a taxpayer for long-term health insurance.

Today there are about 65 companies that are licensed and selling long-term insurance policies. As of last April, there were over 420,000 long-term policies in effect. The long-term insurance market is just beginning to grow. Insurance companies are concerned with risks, tax treatment of insurance reserves, and Congressional intervention in their market. I feel that we should encourage the growth of private long-term care insurance policies. H.R. 4929 provides incentives for individuals to purchase such insurance. As a result we can help pull the demand for long-term care policies along and speed up the growth and maturity of the long-term insurance market.

By enacting H.R. 4929, and similar legislation, we can provide incentives and rewards for individuals who care for their elderly family members and give people a little credit for planning for long-term health care in their future. By doing this we allow families to take care of their own. They can do this far better that the government. We must keep family needs and concerns in mind when we address the long-term care issue. I hope that the Committee will carefully examine H.R. 4929 and I thank you, Mr. Chairman, for this opportunity to address the committee today on a topic of such major concern to all Americans.

Congresswoman Barbara B. Kennelly
Statement on long-term health care before the Health Subcommittee of the Ways and Means Committee
August 2, 1988

Mr Chairman. We are presently facing a crisis when it comes to the health of our nation's elderly. Health care costs are skyrocketing, and more and more people are forced to choose between bankruptcy and quality long-term care

We must do something about spouses and/or families who are going broke trying to provide long-term care for a relative. Fifty percent of all couples are impoverished within six months after one spouse is admitted to a nursing home, and 70 percent of all single people go broke within three months. With nursing home care stays averaging 408 days, these figures add up to poverty - and even worse - bankruptcy.

As we begin to examine policy alternatives in this area, we are forced to face up to the budget deficit, and the fiscal realities that come with reducing it. The government cannot shoulder a $30 or $40 billion medical bill in the current climate.

That's why I have introduced a bill that would encourage government, private insurance and individuals to work together to provide long-term care. My legislation, called "The Partnership for Long-Term Care Act", would cover long-term care expenses - at home and in nursing homes - while protecting a certain amount of the family's assets so bankruptcy would not be the eventual outcome of providing quality care for loved ones.

This legislation is based on the asset-waiver approach, under which Medicaid and private insurance would work together to create plans for long-term care. People would decide how much of their assets they wish to protect, and then purchase insurance to cover that portion. Once the value of their insurance, and unprotected assets runs out, they would immediately become eligible for Medicaid.

Under our present system, people must spend all their assets before reaching Medicaid eligibility. This is an irresponsible and ineffective system, and it is ruining the lives of thousands of Americans each year. Under my approach, the price-tag of long-term care is not poverty, either for families receiving care, or the American taxpayer. My approach deals with the problem in a fiscally responsible manner, and I urge you to look into the asset-waiver approach as an effective way to handle our present long-term health care dilemma.

Thank you Mr. Chairman.

STATEMENT BY
HON. MARILYN LLOYD
ON
LONG-TERM CARE

SUBCOMMITTEE ON HEALTH
HOUSE WAYS AND MEANS COMMITTEE
TUESDAY, AUGUST 2, 1988

MR. CHAIRMAN,

I WANT TO THANK YOU FOR HOLDING THIS HEARING ON LONG-TERM CARE, WHICH IS THE MAJOR CATASTROPHIC HEALTH CARE EXPENSE FACED BY OUR ELDERLY CITIZENS.

FOR THOSE ELDERLY WHOSE OUT-OF-POCKET HEALTH CARE EXPENSES EXCEED $2,000 A YEAR, 80 PERCENT GOES TOWARD NURSING HOME CARE --- THE COST OF WHICH CURRENTLY AVERAGES $26,000 PER YEAR. THOSE NUMBERS ARE PARTICULARLY ALARMING WHEN ONE STOPS TO CONSIDER THAT MANY OF OUR NATION'S WORKERS DON'T EVEN COME CLOSE TO EARNING THAT MUCH PER YEAR. WHAT IS EVEN MORE FRIGHTENING IS THAT THE AVERAGE NURSING HOME CARE BILL COULD BE AROUND $158,000 BY THE YEAR 2020 WHEN MANY OF TODAY'S WORKERS WILL HAVE RETIRED.

WHERE DOES THIS MONEY COME FROM? A SURPRISING NUMBER OF PEOPLE THINK IT COMES FROM MEDICARE --- BUT THE SAD TRUTH OF THE MATTER IS THAT MEDICARE PAYS ONLY 2% OF THE $40 BILLION THAT CURRENTLY GOES TO NURSING HOMES PER YEAR. THE REMAINING 98% COMES FIRST OF ALL FROM THE RESIDENTS THEMSELVES, AND WHEN THEY HAVE EXHAUSTED THEIR FINANCIAL RESOURCES, THE BALANCE IS PAID FROM THE MEANS-TESTED MEDICAID PROGRAM.

AS ALL OF US HERE KNOW, THE REAL VICTIMS OF THIS SYSTEM ARE THE SPOUSES OF NURSING HOME RESIDENTS, MANY OF WHOM ARE IMPOVERISHED BY STATE MEDICAID REGULATIONS THAT SEVERELY LIMIT THE AMOUNT OF INCOME AND ASSETS THAT CAN BE RETAINED FOR THEIR OWN MAINTENANCE AND SUPPORT.

WE DID ADDRESS THIS PROBLEM IN THE MEDICARE CATASTROPHIC PROTECTION ACT BY GRADUALLY RAISING THE AMOUNT OF INCOME THAT MAY BE RETAINED BY THE COMMUNITY SPOUSE OF A MEDICAID PATIENT TO 150% OF THE FEDERAL POVERY LEVEL BY 1992, AND BY ALLOWING THE SPOUSE TO KEEP $12,000 IN LIQUID ASSETS. BUT, ARE THESE MEASURES ADEQUATE FOR AN AGING SPOUSE WHO ALSO FACES THE RISK OF ENTERING A NURSING HOME. THE ANSWER IS AN OBVIOUS "NO".

EVEN SO, THIS WAS PROBABLY THE MOST IMPORTANT STEP WE TOOK TOWARD ALLEVIATING THE BURDEN OF NURSING HOME CARE ON OUR NATION'S ELDERLY. OTHER PROVISIONS OF THE NEW LAW, SUCH AS THE EXPANDED SKILLED NURSING FACILITY, HOME HEALTH, HOSPICE AND RESPITE CARE COVERAGE, WILL ALSO HELP TO EASE THE COST OF EXTENDED-CARE. BUT, THEY OFFER, LITTLE IF ANY REAL HELP TO THE SEVERALLY DISABLED PERSON WHO IS FACING A LENGTHY STAY IN A NURSING HOME.

AS THE FIGURES SUGGEST, WE ARE LOOKING AT A MULTI-BILLION DOLLAR PROBLEM WHICH COULD EASILY BECOME A MULTI-TRILLION DOLLAR CRISIS OVER THE NEXT COUPLE OF DECADES. IT IS OBVIOUS FROM THE NUMBERS THAT NO ONE SECTOR OF OUR SOCIETY CAN AFFORD TO BEAR THE BRUNT OF THE COST ALONE. BUT, BY MOBILIZING ALL SECTORS IN A COOPERATIVE APPROACH, WE CAN DEVELOP A COMPREHENSIVE NATIONAL LONG-TERM CARE POLICY --- ONE THAT OUR SOCIETY CAN AFFORD.

THE SUBCOMMITTEE IN ITS ANNOUNCEMENT OF THIS HEARING, ALLUDED TO SUCH A PARTNERSHIP IN THE CONCLUSION OF ITS BACKGROUND NOTES BY STATING THAT --- "BOTH PUBLIC AND PRIVATE INITIATIVES ARE NEEDED TO FINANCE LONG-TERM CARE. THE ISSUE IS HOW TO STRIKE THE APPROPRIATE BALANCE BETWEEN PUBLIC AND PRIVATE FINANCING."

OVER ONE HUNDRED BILLS HAVE ALREADY BEEN INTRODUCED IN THE CONGRESS, SOME OF WHICH SEEK TO ESTABLISH A SHARED RESPONSIBILITY APPROACH TO THE FINANCING OF LONG-TERM CARE. SENATOR MITCHELL HAS OFFERED SUCH AN APPROACH IN HIS BILL, S. 2305, WHICH HE INTRODUCED AS A VEHICLE FOR OPENING A PUBLIC DIALOGUE ON LONG-TERM CARE. SENATOR MITCHELL'S PLAN WOULD EXPAND MEDICARE TO PAY FOR HOME CARE --- BUT AS A COST-SAVING MEASURE, IT WOULD REQUIRE INDIVIDUALS TO PURCHASE PRIVATE INSURANCE TO PAY FOR THEIR FIRST TWO YEARS IN A NURSING HOME. ONE OF THE PROPOSALS THAT I'VE BEEN LOOKING AT ON THE HOUSE SIDE WHICH I FEEL OFFERS A GREAT DEAL OF PROMISE IS THE BI-PARTISAN DAUB-DONNELLY BILL, H.R. 3900.

THIS PROPOSAL SEEKS TO INVOLVE EMPLOYERS BY PROVIDING INCENTIVES FOR THEM TO OFFER LONG-TERM HEALTH CARE BENEFIT FOR CURRENT AND RETIRED EMPLOYEES THROUGH PENSION PLANS. IT ALSO PROVIDES INCENTIVES FOR INDIVIDUALS TO PURCHASE LONG-TERM CARE INSURANCE BY (1) TREATING THE COSTS OF LONG-TERM CARE INSURANCE PREMIUMS AS AN ABOVE-THE LINE DEDUCTION FOR INCOME TAX PURPOSES; (2) PERMITTING THE TAX-FREE WITHDRAWAL OF MONIES FROM AN IRA ACCOUNT TO PURCHASE LONG-TERM INSURANCE; AND (3) ALLOWING THE TAX-FREE CONVERSION OF LIFE INSURANCE POLICIES WHEN THE PROCEEDS ARE APPLIED TOWARD THE PURCHASE OF LONG-TERM CARE INSURANCE.

IN ADDITION, THE BILL WOULD PROVIDE MEDICARE COVERAGE OF BOTH HOME HEALTH AND NURSING HOME CARE COSTS FOR WHICH BENEFICIARIES WOULD PAY A DEDUCTIBLE IN PROPORTION TO THEIR INCOME.

IF THERE IS AN ACHILLES' HEAL IN THE DAUB-DONNELLY PLAN, IT IS THE PROVISION THAT WOULD CHANNEL 60% OF ALREADY-SCHEDULED INCREASES IN THE OASDI TAX RATES TO THE MEDICARE HOSPITAL INSURANCE FUND. THIS PROVISION IS TROUBLING TO ME SINCE IT USES A "ROB PETER TO PAY PAUL" MECHANISM THAT WOULD ENDANGER THE LONG-RANGE SOLVENCY OF THE SOCIAL SECURITY PROGRAM. IT MAKES NO SENSE TO ME TO SOLVE ONE PROBLEM BY CREATING ANOTHER.

BUT, LIKE SENATOR MITCHELL'S PLAN, THE DAUB-DONNELLY BILL DOES OFFER SOME GOOD FEATURES WHICH WE SHOULD CONSIDER AS WE SEEK TO DEVELOP A NATIONAL LONG-TERM CARE POLICY.

THANK YOU, MR. CHAIRMAN. I LOOK FORWARD TO WORKING WITH YOU AND THE MEMBERS OF YOUR SUBCOMMITTEE AS YOU CONTINUE YOUR EFFORTS TO DEVELOP A SENSIBLE AND AFFORDABLE RESPONSE TO AN ISSUE OF CRITICAL IMPORTANCE TO OUR NATION.

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EDWARD J. MARKEY
7TH DISTRICT, MASSACHUSETTS

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CHAIRMAN
SUBCOMMITTEE ON
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Testimony of the Honorable Edward J. Markey before the Subcommittee on Health

Hearing on Long-Term Care

August 2, 1988

Mr. Chairman and members of the Subcommittee on Health, I want to congratulate you for holding this hearing on America's growing long-term care crisis.

Creation of a comprehensive long-term care program is urgently needed and long overdue. The cost of long-term care in our country has escalated over the past years to reach a level of over $40 billion. In my own state of Massachusetts, the total cost is now over $1 billion each year. Nationwide, over half of that long-term care bill is paid for through private mechanisms, placing an especially severe burden on older Americans and families struggling to live on already limited incomes.

As serious as the problem is today, it will worsen considerably absent Congressional action. According to demographic predictions, the number of senior citizens who need long-term care will grow from seven million to over nineteen million by the year 2040. As the above-65 population doubles and the above-85 population triples, a larger and larger burden will be placed on an already strained health care system.

We do not have to rely solely on the statistical record, however, to know that the long-term care system is broken and desperately needs to be fixed. The experiences of our families, friends and constituents provide dramatic evidence of the holes in the health care safety net. Each of us has firsthand knowledge of the individual tragedies occurring daily because our nation lacks a comprehensive and effective federal long-term care policy. If we do not act now, increasing numbers of families will face medical, emotional and financial crises as they attempt to cope with the exorbitant costs and limited resources of our long-term care system.

Those costs represent the greatest obstacle to care for all but the very wealthiest of Americans. The average nursing home cost is over $60 a day, while home care costs can range from $25 to $70 per day. Annual costs of $20,000 or $22,000 are far beyond the financial means of elderly individuals, who have average incomes of about $10,000, or older couples whose yearly income averages $26,000. While many older Americans gamble that they will be among the fortunate who do not require long-term care, others have sought some protection through long-term care insurance. Even low-income seniors have struggled to pay for private coverage. A report by the Commonwealth Fund found, for instance, that 42 percent of the poor elderly buy Medigap policies costing $500 a year, ten percent of their annual income.

Three out of four Medicare beneficiaries purchase Medigap insurance, many in the belief that those policies will cover their basic acute and long-term care needs. This is not the case. Many of the policies they buy lack the basic long-term care coverage that they mistakenly believed they have purchased. An April 1987 report by the Massachusetts Special Commission on Elderly Health Care, "Beyond Chaos and Catastrophic Costs: A Long Term Care Plan for Massachusetts Elderly," found that long-term care policies covering nursing home care were available but that "(e)xclusions and stipulations in these policies leave elders uncertain that they will actually be covered, if they need long term care." Moreover, the report discovered policies failed to cover home health care costs at all.

The provisions of H.R. 5085, the Long Term Care Insurance Standards Act of 1988, represents an important attempt to provide health care consumers with clear and adequate information on policy coverage and benefits. While I support enactment of minimum insurance disclosure standards, I would like to suggest some additions to this legislation.

First, I believe that the uniform disclosure statement should include a description not only of the events that qualify for coverage but of typical long-term care services that do not qualify for coverage. This is particularly important since many insurance purchasers may not fully understand the distinction among services and may assume that items are covered which may be disqualified for payment. Similarly, a mechanism by which policy holders can obtain information in advance as to whether specific health care services will qualify for payment would be a significant improvement.

Second, I would like to recommend that the public be allowed to petition the Long-Term Care Insurance Panel for improvements in the minimum standards. As long-term care policies become more prevalent, it is likely that new concerns and proposals will arise. Therefore, the public should be provided with an avenue by which it can suggest modifications in the initial requirements.

Despite the obvious importance of H.R. 5085, it must be recognized that improving the quality of private long-term care insurance is not enough. According to the Brookings Institute, only three percent of the Medicare beneficiaries with Medigap policies have long-term care coverage. While Brookings predicts that the number of policies will grow, it estimates that private insurance will account for only 12 percent of total nursing home expenditures and will be affordable by only 26 to 45 percent of the elderly population. And again, I emphasize the evidence from Massachusetts that important long-term care costs such as home care are missing from private policies.

We cannot rely solely on private insurance to meet long-term care needs -- a comprehensive federal solution will be necessary. Members of the Ways and Means Committee and of the Energy and Commerce Committee on which I serve have already given a great deal of thought to the scope and shape of that solution. As we continue work in this area, I believe that there are a number of critical principles which must be included in any final legislative approach.

First, any program must be comprehensive in covering not just the elderly but persons of all ages who require long-term care because of physical of mental disabilities. We have focused on the needs of older Americans, those who are most likely to need long-term care assistance. Obviously, senior citizens and their families need help. But it is also important to remember that long-term care costs and availability problems can be just as devastating when the person needing care is a child or an adult.

Let me give just one personal example of how the non-elderly as well can fall through the holes of the long-term care system. One of my constituents, Pasquale D'Amore, has a son James who was born with deformed limbs, microcephaly of the brain, severe epileptic seizures, and cerebral palsy with spastic quadriplegia. James is also blind. Because his medical problems are caused by a genetic problem, his parents cannot have any more children. Doctors who have worked with the family have stated that they feel James is still alive today because of the loving attention that he has received from his parents. There is no federal long-term care policy that will help meet the needs of James and his parents. Rather, our general policy is to tell the D'Amore's that they can receive support only if they agree to institutionalize their son.

This brings me to my second point, the need to create a long-term care policy that provides benefits not just for institutional care but for home and community-based care as well. The D'Amore's are fortunate in that Massachusetts has adopted a Medicaid program that provides them with some assistance. Not only does this allow them to share time with their son and to give him the type of care that has caused his survival, it significantly reduces the cost of his care. In Massachusetts, the cost of institutional care for a child like James has a median pricetag of about $80,000. Still, other federal assistance which is available to families of institutionalized children is still denied to the D'Amore's.

Most elderly as well prefer to stay with their families and friends, as opposed to being uprooted and limited in their surroundings and independence. Where community care is a viable and cost-effective alternative, it should be encouraged and funded; not discouraged and disallowed as under current policies.

The concept of cost containment is another essential ingredient of long-term care legislation. Under the status quo, my state expects its own long-term care payments to rise from $800 million to over $2 billion by the year 2010. An expenditure increase of that nature would not just require difficult choices to be made among competing health care programs, it would affect the ability to fund other government-provided services such as education and job training. Promoting least-cost but appropriate care alternatives is just one way to help ensure that program costs are be kept under control.

Additionally, it will be necessary to look at financing sources beyond general federal or state revenues, including uncapping the Hospital Insurance payroll tax and beneficiary contributions. In considering those alternatives, however, I believe that we must abide by two key elements of the Medicare Catastrophic Coverage Act of 1988: that all individuals will receive the same level of benefits regardless of income and that any beneficiary payments will be progressive in nature so that the poor and near-poor will be protected.

Finally, quality of care and comprehensiveness of services must be built into a long-term care policy from the beginning. Certainly, available services should not be any less restrictive than those currently offered under the Medicaid program.

Mr. Chairman, my state of Massachusetts has taken a pioneering role in the health care field, and I am proud that it has taken action on home care, Medicaid waivers and, of course, landmark legislation on universal access. But we recognize that the long-term care crisis cannot be left for individuals or even individual states to solve. It must be addressed on a national basis. While the questions before us will be difficult and complex, we must take comfort in the fact that the vast majority of the American public is behind our efforts.

Again, I want to commend the Subcommittee and pledge my desire to work with you in the development of a comprehensive and effective federal long-term care policy.

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DAVID R. OBEY

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July 28, 1988

The Honorable Fortney Pete Stark
Chairman
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
Washington, D. C. 20515

Dear Chairman Stark:

As you know, I have introduced HR 4763, the Long-Term Care Assistance Act of 1988, a companion bill to S. 2305 introduced by Senator George Mitchell. Representatives William Ford and Gerald D. Kleczka joined as original cosponsors; Representatives Norman Lent, Tom Sawyer and Les Aspin also are cosponsors of the bill.

I respectfully request that the introductory statement and the text of the bill be inserted in the record of the hearing before your Subcommittee on August 2, 1988 on the subject of long-term care for the nation's elderly and disabled.

As I stated in introducing the bill, I offer it to indicate that the time for talking is over and the time for commitment to deal with the problem is at hand.

I commend your Subcommittee for beginning the debate on legislative approaches to do that.

Thank you for including the statement and bill in the hearing record.

Sincerely,

David R. Obey
Member of Congress

Enclosures

[THE BILL, H.R. 4763, IS BEING RETAINED IN THE COMMITTEE FILES.]

EXTENSIONS OF REMARKS

LONG-TERM CARE ASSISTANCE ACT

HON. DAVID R. OBEY

OF WISCONSIN

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 8, 1988

Mr. OBEY. Mr. Speaker, I am today introducing a bill to extend Medicare coverage to long-term care, including many areas of coverage that are not presently included in that national program.

The bill is identical to one recently introduced by Senator GEORGE MITCHELL (S. 2305) and it complements the catastrophic health care bill recently approved by Congress and sent to the President for signature.

While there are provisions over which I and others have concerns, it is important, I believe, to offer this well-thought-out proposal for discussion as we begin serious debate on ways to provide protection from bankruptcy for people who incure long-term care costs.

All Americans worry about what will happen to themselves and their family members when they become old, enfeebled, or disabled. It no longer is just the worry of older people. That concern now is shared by children, grandchildren, and great-grandchildren as the Nation's population of elderly people grows larger than in its history.

Today, major long-term institutional and home health care are not covered by Federal Medicare insurance, which many Americans do not realize. To a small extent those benefits are covered by private insurance. That means that only wealthy people can afford long-term nursing care; other people, and that includes those in middle-income brackets, often are forced, if such a need arises, to impoverish themselves to become eligible for State-Federal Medicaid nursing home coverage.

That's not right.

And that's why I believe that an approach like this bill is the best way to rectify the problem we all face today: Spread the cost over the entire population in order to keep costs affordable for Government and for individual families.

BRIEF SUMMARY OF WHAT THE BILL DOES

It allows Medicare to cover a variety of long-term care services in the least restrictive and most cost-effective way possible, providing the maximum opportunity for people to remain in their homes whenever possible.

New services that would be covered include respite care, and more home health and nursing home care than are presently covered by Medicare.

Nursing home benefits would begin after a period in which beneficiaries would be expected to cover the costs of their nursing care, either by private insurance or paying directly for care. After that exclusionary period, Medicare would pay for nursing home care for an unlimited period, with a 30 percent copayment—that is, the beneficiary would have to pay 30 percent of the costs. These provisions, I recognize, are subject to debate and could very well change as the matter is refined through the congressional process. Alternative approaches would be to shorten the period before Medicare begins coverage and to set the copyment on a sliding scale, based on a person's income—the wealthier would pay more, those with lower incomes, less. Such an approach would be my preference and I will work toward that in final legislation.

The bill finances this expanded coverage with new revenues so that the expanded benefits would not add to the Federal deficit.

Financing would come from three revenue sources by:

Eliminating the $45,000 cap on income that currently is subject to the 1.45 percent Medicare payroll tax;

Raising the Medicare part B premium by $2 a month and increasing the "supplemental" premium contained in the catastrophic insurance program—that supplemental premium amount would be based on a sliding scale related to a person's income;

And by applying a 5-percent surtax to estate transfers by gift or inheritance of assets in excess of $200,000.

To be eligible for this bill's new benefits, beneficiaries would have to meet a uniform criteria, including the inability to perform at least two activities of daily living, such as feeding or clothing themselves, or to have significant cognitive problems—such as lack of memory or understanding—accompanied by behavioral problems—common to Alzheimer patients.

Each Medicare beneficiary's needs would be assessed on a case-by-case basis to determine what the most appropriate care should be.

Respite care benefits—to allow a "respite" or time off for family members who daily care for someone at home—would be covered up to $2,000 a year with a 50 percent copayment—that is, the beneficiary would have to pay half of the total cost of the respite care.

Home health benefits would include, for the first time, homemaker and chore aide services such as cleaning and other custodial services which people with functional or cognitive limitations could not perform. Such services allow people who may not need skilled nursing services but who have other impairments to stay in their homes.

Medicaid will continue to support those with low-incomes who could not provide coverage for themselves during the exclusionary period and/or could not pay the 30 percent copayment once benefits went into effect. The money that States are expected to save in Medicaid expenditures will be reapplied to State long-term care expenditures, and the State's Federal matching funds—now 55 percent—adjusted to reflect that additional revenue.

The bill contains two provisions that are intended to protect people's assets so that they are not impoverished by long-term costs. If a person is able to pay for the exclusionary period either by private insurance or direct payments, the assets of the person or spouse would not have to be spent down to a poverty level to make the person eligible for Medicaid—the State-Federal health insurance for the people with low incomes.

In addition, States will be required to pay the premiums and copayments for Medicare beneficiaries whose incomes are at 100 percent of the Federal poverty level.

Tax incentives are included to attract private insurors into the business of selling long-term care policies. They include clarification of existing law:

Which provides that insurance company funds that are set aside to satisfy future long-term care policyholders are tax deductible;

And that long-term care insurance premiums are subject to the same tax deductions now available under existing law for other health insurance coverage.

This bill is designed not only to take up where other measures, including the catastrophic bill, stop for the purpose of hospital and nursing home institutional care, but to expand something that most of us desire—care in the home or community.

HERE IS HOW PEOPLE IN TYPICAL SITUATIONS WOULD BE AFFECTED BY THE BILL

Medicare today

The current Medicare program does not cover long-term care. It covers up to 100 days of skilled nursing home care only after a person has been hospitalized and if they need skilled nursing care on a daily basis. If a person cannot afford the care after that coverage expires, or has spent most of his or her money, the patient may qualify for Medicaid coverage of health care for those with low incomes.

Medicare also has very limited coverage for home health services now. A person must need skilled nursing care on an intermittent basis and be homebound. Many chronically disabled people who could remain in a home setting don't qualify under the current program for home health benefits, and must go to more expensive, often less desirable, nursing homes.

This bill is designed specifically to expand that kind of coverage, which most people prefer if it is suitable and can be provided.

Medicare is paid for by payroll taxes on the general population and by premiums paid by beneficiaries themselves for doctor's office visits and care (part B).

This bill would add $2 per month to the basic part B premium as well as a corresponding increase in a "supplemental" premium for all Medicare beneficiaries who want long-term coverage. That premium, like "supplemental" premium in the catastrophic health care bill, would be set on a sliding scale related to a person's income.

Two new features related to Medicaid are included in this bill. One, like the catastrophic health care bill, would protect the assets and income of an institutionalized spouse so he or she would not have to become impoverished if they were covered by Medicaid. A second

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.

feature would require States to buy the same Medicare benefits in this bill for people who meet the Federal poverty guidelines, many of whom have more money than their State's Medicaid poverty level but who are too poor to have health insurance or pay for expensive health care.

PERSON WITH SHORT-TERM NURSING HOME STAY

Unless we can find the money to shrink the gap, someone who requires nursing home care for less than 2 years would be expected to pay for the care either through privately purchased insurance coverage or directly to the nursing home. This bill is designed to encourage more insurance companies to offer long-term care policies. Those policies may cost about $800 a year—based on figures from studies of 1986 policies. Nursing home care can cost as much as $2,000 per month.

As I have said, the exclusionary period before Medicare benefits begin is troublesome and this section of the bill is subject to discussion and possible change. I would like to see it shortened if we can find the money to do it. A great deal depends on the extent to which private insurance becomes more available and attractive to people. A person who could not afford the nursing home care would still be able to qualify for Medicaid coverage, as is the case now.

PERSON WITH LONG-TERM NURSING HOME STAY

Someone who has been in a nursing home for the required period would have all such care covered by Medicare after that time and for an unlimited time after that. The beneficiary would have to pay 30 percent of the nursing home charges, which would be determined by the Secretary of the U.S. Department of Health and Human Services. People could continue to buy MediGap private insurance to pay that copayment. A person who could not afford the 30 percent copayment would qualify for Medicaid. Another approach, which I believe to be more equitable, is to base the copayment on a person's income level. That would allow for more income to the program and a shorter exclusionary period.

PERSON WITH HOME HEALTH CARE

Someone who needs chronic home care would be able to receive a variety of services under this bill, including health care as well as chore services that are custodial so the person could remain at home. A person would have to have incurred $500 in home care expenses—the deductible—before Medicare would cover them, after which a beneficiary would have to pay 20 percent of the cost of the care after the first 20 days out of a hospital. There is no limit on the amount of such care that is covered by the bill.

In addition, the bill provides for payment of care at home or in a day care center so that family members who care for someone ill could have a "respite" and relief from his or her care-giving duties for a period of time. That "respite care" benefit would be covered by Medicare for up to $2,000 a year in services, of which the beneficiary would pay half of whatever costs were incurred.

CONCERNS THAT NEED TO BE ADDRESSED

Three things concern me about this approach, which will be discussed and refined as we debate the matter.

First. The period in which people would have to pay for these costs is a long time, and unless people purchase or have available to purchase private insurance coverage for that period, they will continue to have to pay the costs of the care themselves. But this is a beginning in providing nursing home coverage.

I agree that the private sector should be afforded the opportunity to be involved in this kind of insurance coverage. However, I am not convinced that this bill has found the answer to assuring that such policies will be available or affordable. The bill does define risk, enhancing the industry's ability to estimate risk. But, although the insurance industry tells us that its members are beginning to sell more such policies, good coverage at affordable rates remains small. Private long-term care insurance, now offered by some 80 companies through half a million policies, pays less than 1 percent of the Nation's nursing home bills, according to an analysis by the American Association of Retired Persons [AARP].

There are some exciting and innovative projects underway in a number of States, including Wisconsin, that are attempting to attract the private insurance industry into providing coverage for people who cannot get or afford health insurance. Those may give us better ideas about how to blend the private and government sector to make sure everyone has insurance and/or health care, which could be included in a Federal program.

Nevertheless, this bill supplements the private sector and does what insurance companies cannot do—it spreads the cost of long-term care insurance over the broadest possible population, thereby reducing the cost per person to a modest sum. I believe that is a viable way to go.

Second. While I support the financing mechanisms in this bill, I think that we need to consider basing not only supplemental premiums but also copayments on a person's income and ability to pay, along the lines of the approach in the catastrophic legislation. That, too, will be subject to debate. No one wants to impose an unfair means test on the elderly; on the other hand, all revenue sources for this program should be considered.

Third. The 5-percent surtax on estate gifts or inheritances exceeding $200,000 should be carefully reviewed to be sure that it is flexible enough not to unfairly penalize the estates of family farmers. There are provisions in the tax law now that help family farmers in transferring their land—installment payments of estate taxes and setting the value of land based on its use rather than its market value. That may be sufficient to protect the family farms from undue taxes when handed down to family members. If not, this provision should be modified.

THE ADVANTAGES OF THE BILL

In short, this bill goes a long way toward insuring the best "bang for the buck" in national long-term-care protection.

It complements the catastrophic coverage that will be in place in the future.

It does not bankrupt the Government Treasury and it protects people from one of their worst fears today—bankruptcy from health care costs in old age.

The people tell us that they want this expanded coverage. Two separate polls recently conducted for the AARP and the National Association for Home Care show overwhelmingly that the majority of Americans favor a Federal long-term-care program similar to Medicare and Social Security, and are willing to pay modest increases for such programs. Eighty-four percent of middle-aged and older Americans told the AARP that, and 8 out 10 Americans favor a Federal program to provide home care for the chronically ill, according to the Home Care Association. The only way to keep the cost small for expanded Federal health care programs is to spread it across the broadest possible population. That's what we are doing with this bill.

The facts are staggering:

Seven in ten older people who live alone are reduced to poverty-level incomes after 13 weeks in a nursing home, and exhaust both their incomes and financial assets within 1 year, according to the House Select Committee on Aging.

By the year 2000, 13 percent of the population of the United States will be 65 or older, 20 percent by 2024.

The over-85 population is expected to be seven times as large by 2050 as it was in 1980.

Twenty percent of the elderly now require home health or nursing home care, and that need will rise threefold by the year 2040, according to the Department of Health and Human Services.

In Wisconsin, by the turn of the century there will be 40,700 more people over age 85—a 62 percent increase from today—and the State will need 14,000 more nursing home beds or the equivalent care in the community, according to the Wisconsin Department of Health and Social Services.

This bill will be criticized by those who think it does not go far enough and those who think it goes too far. It has shortcomings and debatable provisions. But it builds on and rounds out public and private coverage that has been put in place incrementally over time. It is designed to be fiscally responsible and pragmatic. A shorter exclusionary period, say, for 1 year, necessarily raises the cost—to taxpayers—of more coverage. That may be the preferable way to go. We'll have to see what the people want in that regard.

For that reason, I offer this proposal for discussion. And I hope that discussion will move quickly, as my colleagues in the Senate, BARBARA MIKULSKI, said on joining with Senator MITCHELL in sponsoring the bill, from the living rooms, kitchen tables, and bedsides of loved ones to the committee rooms of Congress for implementation so that people will soon know they can have dignity without fear of impoverishment for the health care they need in their elder years or if they become disabled.

Such care is going to cost money—out of the private or public pocket, or both. Now, the costs for those receiving this care is being financed largely by private dollars. And if someone can't afford the care, it means that they are being abandoned in such situations.

No civilized society can do that, in my view.

Whatever "cost" is applied to the bill—and we do not have a complete estimate from the Congressional Budget Office at this time—it must be remembered that this approach redistributes the costs more equitably across the population, so that, for modest per-person costs for the Federal insurance, those people who need this kind of expensive and long-term care will be covered without crippling costs to themselves and their families. What we're doing with this bill is providing a national "insurance" against long-term care costs through both private and public coverage.

Mr. Speaker, I am not a member of the committee that has jurisdiction over the development of national health care legislation. I recognize that other people will have a greater opportunity to affect the content of such bills. However, I offer this bill to indicate that the time for talking is over and the time for commitment to deal with the problem is at hand.

It is my hope that this approach will have bipartisan support so that we can begin the legislative debate on a workable, affordable long-term care program. I am fully aware that the bill leaves a number of unacceptable gaps, but unless those of us who favor action can coalesce around several alternatives, nothing will be done.

I thank Senator MITCHELL for his leadership on this issue.

GERALD S. PARKER
11 Shore Acre Drive
Old Greenwich, CT 06870

Subcommittee on Health
Committee on Ways and Means
U. S. House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

SUBJECT: Long Term Care

This statement is submitted for the record of the hearing of September 26, 1988.

I am a private citizen and represent no organization; I make this statement because I have substantial expert knowledge of the subject. My qualifications are as follows:

I organized the individual health insurance operation of The Guardian Life Insurance Company of America in 1951-1952 and ran it for over 30 years until I retired at the end of 1981. While there, I was instrumental in developing the first lifetime guaranteed renewable major medical policy in 1955. Some of those policies are still in force. I developed the first Medicare Supplement policy to be sold in this country. It was introduced on July 1, 1966, the day Medicare became effective. It had a benefit pattern generally comparable to, but more liberal than, the minimum standards adopted by the Congress and the National Association of Insurance Commissioners in 1979. The Guardian and I learned a great deal from both the successes and the financial failures of both these highly experimental, but very valuable coverages.

The problem imposed by the need for long term care, particularly custodial and home care, faced by many of our nation's elderly well merits attention. Numerous private insurance companies and some blue cross/blue shield plans have been experimenting in this field for a few years - and only a very few.

Some things have been learned, and much remains to be learned. Most of the policies now offered focus on skilled nursing home care with some benefits, usually at about half rate, for custodial and home health care.

Most of them require 3 days prior hospital confinement for benefits, following the Medicare pattern about to end this year. More and more are starting to waive that. It makes little sense to the buyer, and a high proportion of nursing home patients enter nursing homes without prior hospitalization. Many enter custodial care without prior skilled care. Gradually, some of the insurers are recognizing this and meeting the real need more effectively. Others will follow.

When I retired less than seven years ago, none of this coverage was available. Now at least a dozen or so really prominent companies offer it. For examples, there are the Aetna L&C, Bankers Life & Casualty, John Hancock, Mutual of Omaha, and the Connecticut Blue Cross just in my town of Greenwich. There are several others with policies approved in Connecticut.

I believe that another five to seven years will see the benefit patterns pretty well standardized at high quality levels with sufficient choices to satisfy the needs and want of a large proportion of the self supporting population.

I believe Congress should indeed hold hearings on this subject and study the testimony carefully, but I strongly urge that it not rush into legislation mandating or controlling coverage or prices now when even the most knowledgeable health insurance experts and actuaries consider it highly experimental, have only rather rough estimates of what the costs of the coverage will ultimately turn out to be and what the benefit patterns will finally be.

One thing is very clear to me. To be successful, this coverage will best be largely funded during the working years. As people age, the annual insurance cost rises dramatically. For it to be affordable for people in and beyond their middle seventies when nursing home care begins to be needed often, large reserves must be built up long before the benefits are needed.

The funding of long term care insurance should resemble the pattern of pension funding, not group term life insurance or health insurance under which premiums are based on attained age.

A look at some illustrative premium levels for just one good plan will illustrate this. Here are annual premiums for a large life insurance company's policy providing $100 a day in skilled or intermediate nursing care, half benefits for custodial or home care, no prior hospitalization required, three year lifetime aggregate benefit period, 20 or 100 day wait in appropriate care before benefits are payable:

Issue	Elimination	Periods
Ages	20 days	100 days
40-44	$ 208.63	$ 178.78
55	$ 416.56	$ 341.85
60	$ 641.36	$ 519.12
65	$1,054.17	$ 846.12
70	$1,746.96	$1,398.00
75	$3,308.83	$2,647.42
79(maximum)	$5,222.07	$4,192.64

I do not contend that these are necessarily the correct rates for the coverages, and I doubt if anyone really knows yet. But I do believe that the kind of escalation they show is approximately correct. That is, they take into account reasonable interest rate assumptions for accumulation of reserves, mortality, and what is known about morbidity. But these are designed as issue age level premium rates. Of course they cannot take inflation into account, and the company offers to adjust coverage triennially on an attained age basis to deal with inflation as best it can.

I do believe this illustration should illustrate the impracticality of making most of the elderly pay for their own long term care insurance after they are old.

No matter who is going to pay for this coverage, whether it be individuals, their employers, or the government, it should be done on a level premium, prefunded basis.

I hate to think of the federal government attempting to do it and setting up the huge reserves that will be needed in government trust funds like the Social Security Trust fund - invested in government bonds and thus being promptly spent for the regular expenses of the government and not actually saved at all.

Such funds invested in industry, on the other hand, could be an immense source of capital for industry.

I urge that your committee disseminate the testimony at its hearing widely, continue to monitor the situation every couple of years, but take no legislative action now.

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STATEMENT OF THE HONORABLE E. CLAY SHAW BEFORE THE WAYS AND MEANS SUBCOMMITTEE ON HEALTH

AUGUST 2, 1988

Mr. Chairman, I would like to thank you for calling these hearings on a topic of crucial importance to our nation's seniors and disabled: long-term health care.

Long-term care has received increased attention due to the efforts of our colleague, Claude Pepper, to pass legislation to assist those among us who need help paying skyrocketting health care costs. The catastrophic health care bill we passed in June will help reduce some costs, but, as Claude Pepper reminds us, more needs to be done to help those with serious long-term illnesses pay for home- or community-based care.

The federal government cannot assume the entire burden of financing these costs. Our task in Congress is to find the right balance between public and private initiatives to cover these expenses.

Already there is a growing private market for long-term care insurance, as Americans become more aware of the threat posed by serious illness to their future financial security. The number of long-term care policyholders increased from 120,000 in 1983 to more than 500,000 last year.

Our role in Congress, as I see it, is to encourage Americans to plan for their future long-term care needs while providing a favorable and stable climate in our tax structure and benefit programs for private long-term care funding efforts. We must also devise a system to help those who cannot afford to pay their long-term care costs.

As the newest member of the Ways and Means Committee, I look forward to participating in the important discussions and debates on how we should go about encouraging enrollment in private plans, and what kind of "safety net" public assistance program we should create for those who need it. I am pleased that there is so much interest in seeking a solution to the growing problem of financing long-term health care costs.

WRITTEN STATEMENT OF ELAINE FRAZIER SMITH, RN
TO THE SUB-COMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U. S. HOUSE OF REPRESENTATIVES
OCTOBER 17, 1988

Mr. Chairman and members of the Subcommittee on Health, I am Elaine Frazier Smith, RN and a Master's degree candidate in Community Health Nursing at University of Maryland. I appreciate the opportunity to file written testimony on behalf of long-term care for Medicare elderly and disabled beneficiaries, particularly for those persons with Alzheimer's Disease (AD) and related disorders.

The Office of Technology Assessment Task Force (OTA, 1988) states that the life expectancy at birth in the United States was 47.3 years in the year 1900. It was 74.5 years in 1982. In addition it states that longevity among those over 65 years of age has increased dramatically in the last decade. The number of AD patients is growing at about the same rate as the older population and is expected to increase 60% by the year 2000. Without a cure or prevention it is expected that 7.4 million Americans will be afflicted by 2040. There are 2.5 million patients presently with AD. This is five times the estimate made 10 years ago by the National Institute for Aging (OTA, 1988).

AD has been called the disease of the century. The medical and social dimensions are staggering (Reisberg, 1983). According to the Alzheimer's Disease and Related Disorders Association, $35 Billion was spent on AD patients in 1986. This included nursing home and other long term medical care. In addition there were the unmeasurable emotional and social costs (OTA, 1988).

With the cost of health care rising and the life expectancy in our nation increasing, it is logical to assume the health care cost of chronic illness will also increase. Good coordinated long term health care legislation could help keep this cost at a minimun.

Medicare was designed using a model for acute illness. This model does not adequately serve for long term care of patients with chronic illness. Those patients require continuity over a long period of time.

Many appropriations have been made for research and demonstration projects related to chronic illnesses including AD and related disorders. Are we to allow those not included in these efforts to go unaided and in some cases become destitute until researchers find cures?

For several years AD has been described as a major public health problem (Katzman, 1986). AD is a type of dementia characterized by multistages of progressively worsening physical and cognitive symptoms. It results in total dependency and ends in death. Typically there is an initial loss of short term and them long term memory. Eventually an inability to reason, speak, think, or care for one self takes place. The patient is awake and aware in the early phases and is often plagued with social avoidance, fearfulmess, pranoia, and delusions. The patient may develop irritability and aggression, verbal and/or physical, as he looses control of others, his environment, and finally of self. This is extremely devastating to the patient and the family.

At present 80% of patients with AD are cared for at home. Actually because the patients are being cared for at home, costs to Medicare for expensive hospitalizations are being delayed and in some cases prevented.

Typically for 2-10 years the family caring for an AD patient at home struggles with the herculean task of caring. This process is very vivedly described by N.L. Mace and P.V. Rabins (1981) in The 36-Hour Day and by D. Cohen and C. Eisdorfer (1986) in The Loss of Self. These patients and their families need help. Many do benefit from medical care, occasional need help. Many do benefit from medical care, occasional hospitalization for a concurrent acute medical problem, and physical therapy if necessary through Medicare and/or private insurance. What is not covered is personal care, elder sitting, and respite care for those caring for the patients at home.

For most people, healthy or not, young or old, assistance with personal care means help with a bath or shower and requires one other person, a relative or close friend.

For a person with AD it can sometimes mean a complete bath or shower given by two to three strong, calm people capable of allaying fears, minimizing hallucinations, and protecting the patient from hurting himself. Such a qualified person or persons should examine the patient for any physical evidence of physiological disturbances the patient is unaware of and discuss these and any other facts which are of concern to the care giver. Referral and followup care would then need to be considered and discussed. From agencies in the Baltimore area the private cost of a registered nurse is approximately $22.00 per hour.

Elder sitting can often be done by a neighbor or friend but some patients are so paranoid or belligerant that they require skilled professional sitters. The average cost is $10 per hour.

AD is an incredible physical and emotional strain on the family members and especially on the primary care giver. About one half of these caregivers suffer a clinical depression. To prevent this and/or to treat this, an occasional weekend away for the primary caregiver is desirable. The cost of replacing the caregiver for even one 24 hour period can be staggering.

I have had the personal experience of being the primary caregiver to a family member with AD for six months. The emotional and physical stress was unmeasurable. The financial cost was approximately $15,300.

1 hr/day assistance with personal care	@ $22/hr	$ 3,960
1 hr/day elder sitting	@ $10/hr	$ 1,800
Downstairs shower installed		$ 500
1 weekend off (cover provided by a nurse friend - otherwise cost of $1056 for 24hr coverage by agency nurse)		$ 400
Forteiture of 24hr/wk job		$ 8,640
TOTAL		$15,300

Please realize I am an experienced nurse, I was able to direct and assist those who came 1 hr/day for personal care, and I had two willing helpful children (ages 11 and 17) who, when they were not in school, helped me with the care for the remaining 22 hours per day. Also, our family was able to absorb the expenses.

Most families affected by AD do not by coincidence have a nurse member available as primary care giver, and many do not have willing young children and/or adequate financial resources.

There is obviously a great need here for changes in Medicare coverage and for participation by the private sector to help cover some of these long term care expenses, particularly the traditionally neglected home care expenses.

Due to advances in medical science and technology, many developmentally disabled, chronically ill, and traumatically injured victims have survived to become senior citizens. These people along with those suffering from AD and related disorders and the frail elderly suffering from disabeling conditions such as blindness, deafness, and arthritis need help. One characteristic of a society which has crossed from barbarism to civilization is that it cares for its less fortunate, its frail, and its very old. So far our society's response to the needs of those requiring long term care has been inadequate and inapporpriate. We have been concerned with the economics of long term care and how its financing is likened to a bottomless pit! What is the social cost to individuals and families?

Traditionally families have been considered the cornerstones of our society. In the case of AD, 80% of the care is given by families. They provide the motivational, emotional, and physical environments in which the patient must operate. Family members have a profound infulence upon each other. When one member has a dementing disorder it changes the roles of family members, including communication and behavior patterns. Successful adjustment to these patterns depends upon the ability of all family members to learn how to interact with the patient, cope with their own feelings, and maintain their own health. If they do not they will become vulnerable . Families are the first line of defense for patients. If families "go", patients' survival in communities become threatened. Also, if families "go", the integrity of our society will be threatened. Certainly we have the expertise and knowledge in the government and private sectors of this great country to create a solution to this blight on our supposedly advanced society.

As a nurse who believes in the value of human life, in the position of family as a cornerstone of our society, and in the need for continuity of care to insure protection of individuals and families, I urge you, the Subcommittee on Health, to pursue you investigations regarding longterm care.

It is hoped that the efforts of Senators Mitchell, Kennedy, Moynihan, and Melcher along with Representatives Stark, Waxman, and Pepper can be coordinated and that adequate, responsible legislation reflecting a truly advanced society can be introduced and passed as soon as possible in the 101st Congress.

I appreciate this chance to file a written statement and would welcome the opportunity to provide further testimony at any future hearings. Thank you.

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[THE HONORABLE BERYL ANTHONY REQUESTED THE FOLLOWING TESTIMONY BE SUBMITTED FOR THE RECORD, WHICH HE RECEIVED AT AN INFORMAL HEARING HE HELD ON LONG TERM CARE IN HOT SPRINGS, ARKANSAS, ON OCTOBER 22, 1988.]

STATEMENT OF BETTY MADDOX, PRESIDENT

VISITING NURSE ASSOCIATION OF ARKANSAS

BEFORE CONGRESSMAN ANTHONY'S

HEARING ON LONG-TERM CARE

OCTOBER 22, 1988

HOT SPRINGS, ARKANSAS

Mr. Chairman and Members of the Committee:

My name is Betty Maddox. I serve as President of Visiting Nurse Association of Arkansas. Visiting Nurse Association was the first certified Home Health Agency in Arkansas. I have been actively involved in home health care for over 20 years.

I appreciate this opportunity to address the issue of long-term care, because the majority of patients we serve are the frail elderly who are the most at risk of needing long-term health care services. I would like to commend you, Mr. Anthony, for holding this hearing and taking action to address the vital issue of the long-term needs of the citizens of Arkansas and the United States.

HOME CARE EDUCATION

The first step to solving the long-term care crisis is to educate all Americans about the availability and cost-effectiveness of home care. It is time for a federal program for long-term care that is based on professional, high quality health care delivered at home.

In Arkansas we are experiencing the closing of rural hospitals and a shortage of nurses. These two factors will have an additional impact on the crisis we face in long-term care.

MEDICARE AND MEDICAID EXPENDITURE IN ARKANSAS FOR NURSING HOMES AND HOME HEALTH

In the state of Arkansas last year the Medicaid program spent approximately 100 ~~$129~~ million for private intermediate and skilled nursing home care while paying only $5.9 million for home health care and $15 million for personal care. The Medicare expenditure for home care in Arkansas was approximately $7 million. Only ~~22%~~ 14% of these health care dollars was spent for home care.

Reforms should reduce the current bias toward nursing home care by providing financing for home care. Current public spending for home care is still relatively low, and substantial expansion is possible without dramatically changing aggregate long-term care expenditures.

THE NEED FOR LONG-TERM CARE COVERAGE

A fundamental health care need of elderly Americans is coverage of costly care required for chronic conditions. Currently, 80 percent of the cost of all catastrophic illnesses relates to long-term care, and there is very little in the way of help from the public or private sector. The average Arkansas family simply does not have the resources to pay for long-term care. In Arkansas it costs approximately $18,000-$26,000 to keep a private pay patient in a nursing home for one year.

Arkansans saving for retirement have been told or presumed that Medicare and Social Security would cover all their needs. That was the philosophy of the '60's.

Neither public nor private insurance provides protection against the costs of long-term care. Medicare pays only for limited amounts of skilled care and home health care. Arkansas Medicaid pays only for nursing home care, but requires pauperization before eligibility. Most private health insurance provides limited, if any, coverage for long-term care in the home or in a nursing home. New specialized long-term care policies are expensive and riddled with limitations. Although the recently-passed catastrophic health legislation provides for a richer acute care benefit, the Medicare home health benefit still does not cover all acute care needs, nor any chronic care needs.

THE NEED FOR ACTION ON A FEDERAL LEVEL

The Federal government must take the lead in providing adequate coverage for long-term care needs. The private health insurance industry has made some efforts to cover long-term care, but the policies which currently exist are few in number and are riddled with exclusions and limitations. To the extent that policies exist, they typically pay indemnity and not service benefits, and their coverage is limited to nursing home care or includes minimal home care provisions. A May 1987 report by GAO identified serious limitations to most long-term care policies:

- Failure to index benefits for inflation.

- Limitations on renewability.

- Prior hospitalization requirement.

- Exclusions for coverage of mental and nervous disorders. These exclusions have important implications for long-term care insurance policies, where more than half of all nursing home residents may have Alzheimer's disease.

- Focus on skilled nursing care: Many policies require that nursing home care be skilled and that home care services be patterned after the Medicare model.

Given the cost of a comprehensive long-term care policy and the associated risks, it is not likely that the insurance industry will be developing such a policy within the forseeable future. The problem of long-term care requires a national approach to provide a basic range of services, which can be supplemented by the private sector.

Establishing an appropriate Federal role in long-term care would decrease financial pressures on states' Medicaid programs. It would also avoid the disgraceful situation in this country where the elderly are forced to impoverish themselves in order to obtain Medicaid coverage for their long-term care needs.

The Brookings Institute concludes that the most straightforward approach in federal financing of long-term care is adding long-term care benefits to Medicare, with a corresponding increase in contributions to the Medicare trust fund.

The American population favors a federal program to provide long-term care in the home as well. A recent national poll conducted by Louis Harris and Associates shows that 8 out of 10 Americans favor strong federal involvement. Support for such a program was shared by Americans of all ages and bridged all political and regional differences. 82 percent of those responding said they could not afford to pay for costs of providing long-term care either in the home or in a nursing home. 78 percent of Americans polled said they preferred to receive long-term care in their homes over long-term care in a nursing home.

I believe that the foundation of any long-term care legislation should be home care. Prevention of exacerbation of an illness helps prevent a beneficiary from requiring costly inpatient acute care. Only when home care is inappropriate should Arkansans break up families and place seniors in a nursing home. Long-term home care would postpone the need for institutionalization until such time when constant care is necessary for the patient's well being.

Long-term home care improves the quality of life because it is more humane. When care is delivered in the home, the patient is surrounded by his familiar environment and support systems which enables his condition to be sustained. Home care is usually more cost-effective.

Eligibility should not be contingent upon income, but rather need, nor should it be contingent upon prior receipt of nursing home or hospital services. I have concerns with regard to a beneficiary deductible and/or co-pay, which could affect access to services. Elimination of the intermittent and part-time definition for nursing services is necessary since the patient's needs are long term.

A long-term care package should include a range of skilled professional services, such as skilled nursing, physical, speech, occupational, and social services. Professional assessment, evaluation, and treatment of patients with long-term chronic conditions is not now covered and would be essential for a long-term home care benefit.

A home-health aide benefit is necessary to provide personal care (hands on) services, by a trained and qualified individual, which enables a patient to remain clean, fed, and cared for. It should be clear that this service should never be provided without supervision and patient assessment by a professional nurse.

A long-term care program should also offer respite care (companion, homemaker) services that provide well deserved and necessary relief to supportive caregivers.

There should be elimination of the homebound definition that restricts a patient from necessary services that keep a person in the mainstream of life. Attending an adult day care center occasionally or regularly can provide professional and social interaction, again to assist in sustaining the patient's condition.

Additionally, benefits such as emergency life response systems should be included.

I would like to see a long-term care program that is geared to functional disability rather than age. Many young families face destitution through the costs of caring for their chronically ill and disabled children and adults. There is currently a strong bias toward placing and keeping chronically ill children in the hospital and adults in nursing homes.

I believe that past experience with the Medicare home health program supports our view that home health agencies could play a useful patient advocacy role. Although a long-term care program is an entirely new benefit in an area where there is currently little financing, much of the infrastructure is already in place. There are currently 156 home health agencies in Arkansas providing care in the home with much case management experience. By making a long-term care program part of the existing Medicare program, the conditions of participation, newly strengthened by OBRA 1987 and appropriately modified by a new long-term care benefit, would apply to home health agencies.

Utilization management would be an essential feature of any long-term home care program. The numerous demonstration projects that have been conducted to develop long-term care programs and the few private insurance organizations that have actually put a long-term care policy into effect seek to control utilization through the use of "case management."*

Typically, a case manager assesses prospective home care patients to determine their strengths and weaknesses for independent living and determines whether home care or institutional care is appropriate. Because of the potential for conflicts of interest and the long-term nature of the care plan being decided on, third parties are reluctant to leave case management entirely in the hands of the home health agency that is providing paid services. On the other hand, it may not be practical for payors to establish and staff case management systems of their own. One major drawback is the substantial costs entailed in duplicating activities that a home health agency would have to carry out in any event in order to care for the patient.

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* OBRA '87 requires the Secretary of Health & Human Services to conduct four demonstration projects to provide case management services to Medicare beneficiaries with selected catastrophic illnesses, particularly those with high costs of health care services.

In addition, when a third party assumes some degree of responsibility for case management, it usually has to function with a limited amount of information -- less in most cases than is available to the caregiver since the information usually comes from the providers "second hand". Also, a generally accepted uniform assessment has not yet been developed. In any case, third party opinions about informal caregiver availability, medical and nursing needs, and the safety of the home environment can become vague and sometimes quite incorrect.

I believe that the division of responsibilities between payors and home care agency providers should recognize the payor's obligation to protect the program against overutilization and excessive costs. At the same time, the primary responsibility for managing the care of the patient, and serving as the patient's advocate, should be left in the hands of the home care agency. It is the agency caregivers who are trained for assessments, and are in personal contact with the patient on a continuing basis and who are responsible to the patient for his care.

I believe that a balance can be achieved in which the provider remains responsible for case management and the payor can carry out its utilization management responsibilities without an unnecessary, costly and administratively burdensome duplication of patient care planning and review functions.

Any home care proposal should allow for adequate reimbursement reasonably related to the services provided. If the fees for some types of services or classes of patients are profitable while others lose money, patient care could suffer. This would disadvantage the patients that need certain services and threaten the financial stability of agencies that would choose nevertheless to provide those services.

Finally, it is important that there be a clear and definite distinction between the current Medicare home care benefit and a long-term home care benefit. Discharge from the current benefit and eligibility for a long-term home care benefit should be established. Skilled professional services and paraprofessional services that focus on acute medical and nursing needs, whereby treatment is short term and corrects the problem, should be the Medicare and third party payor guideline for current coverage. A long-term home care benefit would focus on the patient's long term skilled and paraprofessional needs where the care is not to correct the exacerbating problem but to watch and prevent the illness from requiring institutionalization.

CONCLUSION

Mr. Anthony, I appreciate the opportunity to be here today and discuss this vitally important issue and I commend you for your leadership in the area of long-term care.

STATEMENT OF THE HON. PETE WILSON (R.-CA)
UNITED STATES SENATE

Mr. Chairman:

I want to commend you for holding hearings on one of the most critical, complex and urgent issues facing Congress: meeting the need for long-term health care coverage. This is an important time for members of the House and Senate to come together and present the many proposals pending in Congress which seek to solve the problem of finding innovative and viable alternatives to make affordable, quality long-term care coverage available to Americans.

These hearings, on long-term care, have enormous significance to the whole of Congress, especially after the House vote on the Pepper Bill this summer. Defeat of the Pepper Bill confirms that Congress still has grave reservations about committing substantial federal funds to finance a further expansion of medicare. Most members agree that Congress can find viable solutions to this problem without imposing what they consider unrealistic new expenditures upon the federal government or upon those who pay for Medicare coverage.

Despite the hard, careful work which went into Congressman Pepper's bill, I believe that the cost alone made it unpassable during this 100th Congress. But that does not mean that Congress cannot and will not pass some type of more targeted long-term care bill this year as we continue to wrestle with the complexities of comprehensive bills such as those proposed by my colleagues, Senators Mitchell and Durenberger.

Everyone in this room knows the urgency of finding ways to make affordable, quality long-term care coverage available to the many Americans who need it. Medicare pays only 2% of nursing home expenses and private insurance covers only 1%. That means that Medicaid and uninsured individuals now must struggle to cover the majority of the financial burden that long-term care makes necessary.

Every time I go home to California, I hear the stories of anxiety and fear. Working individuals worry that without affordable long-term care insurance they must save enough money to try to protect themselves against the eventual enormous costs of long-term care. Retired elderly who still live independent lives agonize that they will lose everything they have worked for because they cannot afford the high rates of private insurance. And many elderly now in nursing homes, live in anxiety and fear as they spend down their savings and risk becoming impoverished.

While Congress labors over how to help those individuals suffering right now because they did not have the opportunity to plan ahead for their long-term care needs, we can do a great deal to make sure that today's workers and perhaps even today's independent retirees do not find themselves in the same awful situation as they grow older. I have seen many interesting proposals which would encourage private insurance companies and employers to offer quality long-term care coverage. The finest idea I have seen thus far came from the Office of Personnel Management. Senators Dole, Durenberger and I have since drafted and introduced legislation, S. 1738, based on OPM'S proposal and Senators Mitchell, Roth, Inouye, Stevens, Graham, Cohen, Sanford, Heinz, Packwood, Cochran, Bond, and Kasten have joined as cosponsors. I understand that members of the House will introduce a very similar bill sometime this month.

OPM proposes to offer optional nursing home and home health care coverage to federal employees who want it. Simply stated, when a young breadwinner selects among employer-offered benefit options, he or she most likely will buy life insurance, determined to provide security to a young family. But, once the children have grown up and become independent, that federal employee begins to worry about his or her own independence in old age, and about becoming a burden to those children.

OPM's plan allows all federal employees regardless of their health status, who have reached the age of 50 and participated in the life insurance program for 10 years, to convert their life insurance to long-term care insurance at no additional expense to the federal government. Since long-term care insurance costs more than life insurance, the employee would have to pay a small additional premium (about $11.00 per pay period). But, the federal government would redirect the contribution it normally makes toward the employee's life insurance, to insurance for long-term care. These two sources plus the reserves in the employees life insurance fund would pay for the new benefit and keep premium costs down. OPM would also make coverage available to spouses, although the employee would have to pay the full cost of the premium.

A pool of 3.1 million active federal workers offers a tempting incentive for insurance carriers to develop a competitive long-term care insurance program. To date, only 500,000 - 700,000 private long-term care insurance policies have been sold. 90% of federal employees participate in OPM'S life insurance program and 655,000 immediately would be eligible when S. 1738 becomes law. Between these employees and their spouses, this proposal alone could double the number of people in this country who currently hold long-term care coverage.

Just as importantly, by taking the lead to create a market in this area, the federal government can create a long-term care "domino effect." More insurance carriers will enter the market in order to compete for the OPM contract. In order to win this competition, insurers will have to offer greatly improved insurance packages, both in terms of price and quality. As the prices come down and the quality goes up, state and local governments and large employers like the University of California, General Motors, and AT&T will gain an incentive to provide a new or convertible long-term care benefit, similar to OPM's, to their employees. And, as more large employers begin to supply this kind of coverage, the prices should drop once again, eventually letting smaller employers and individuals enjoy the benefits of this long-term care competition.

Currently, private long-term care insurance does not play a bigger role because most individuals and employers cannot afford the high cost of the premiums. As two of the nation's long-term care experts, Alice Rivlin and Joshua Weiner, point out in their excellent new book, Caring For The Disabled Elderly:

> "Group insurance especially geared to the nonelderly population would potentially address the problems of high cost and adverse selection. Premiums should be lower in employer-based group policies because... people would be able to contribute over their entire working careers, allowing reserved to build."

Plans such as OPM's, will make long-term care insurance available to the middle class and take it out of the realm of a benefit only available to the wealthy.

The variety of viewpoints expressed at today's hearing confirms that currently, Congress does not have a concrete understanding of how far the private sector can go to meet future long-term care needs. It's difficult to decide what role the federal government must play in filling in the gaps before the private sector has developed its potential.

Senator Mitchell, in his bill, creates a public/private partnership in meeting the nation's need for long-term health care insurance. The vote on the Pepper bill signaled that Congress hesitates this year to move ahead in defining the public side of that partnership. But, I believe members are ready to facilitate development of the private partner. S. 1738 does just that. The data that will result from increased private sector activity in this area will be invaluable as Congress considers more comprehensive proposals in the future.

Thank you again, Mr. Chairman, for the opportunity to speak on a subject of such critical importance. I look forward to working with members in both House and the Senate to develop a national policy on long-term care.